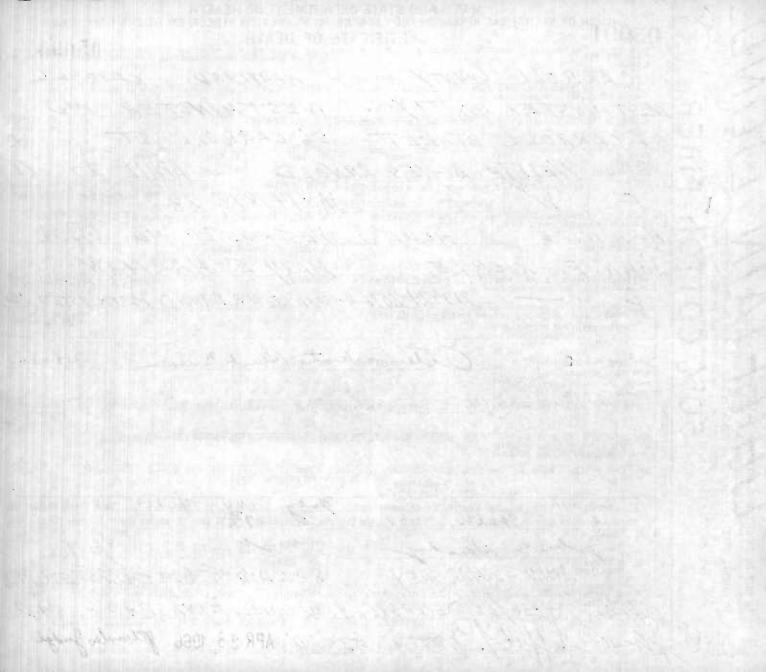
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence a. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (if outside corporata c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) write RURAL and give, nearest town) d. NAME OF HOSPITAL OR INSTITUTION (if not In hospital, give street address) d. STREET ADDRESS a. IS RESIDENCE ON A FARM? OUT YES NO . 3. NAME OF First DATE Middle Month Dev DECEASED (Type or print) DEATH 19 and cor 5. SEX AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS OR RACE 7. MARRIED NEVER MARRIED last birthday) Months WIDOWED T DIVORCED USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY (County & Stete, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) FARM

13. FATHER'S NAME 60 GERTRUDE CONSTANTINI (Yes, no, or unkown) | (If yes give war or dates of service) 1B. CAUSE OF DEATH |Emer only one cause per line for (e), (b), end (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO Conditions, if eny, which (b) gave rise to immedieta cause DUE TO (a), steting the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CENTIFICATION PERFORMED? NO 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH WEDICAL 20c. TIME OF INJURY 20e. PLACE OF INJURY (Home, farm, Month, Dey, Yeer 20d. INJURY OCCURRED 20f. (City or town) (Stete) factory, street, office bldg., etc.) While Not While Hour a.m. at work at work 19 (0. Othat (I) (we) last 21. I certify that (I) (this hospital) attended the deceased from 1.3 19.6...., and that death occured a 22...M, from the causes and on the date stated above. saw the deceased alive on 22b. DATE ATTENDING PHYS. DIRECTOR PHYS. FUNERAL HOSPITA 22d. ADDRESS NAME OF CEMETERY CREMATORY 23d. LOCATION (City, town or county) 23a BURIAL DATE THEREOF 0 ÷ē 25a. REC'D BY REGISTRAR 25b. REGISTRA 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) 15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH funeral and 2 r death. after death, PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY a. STATE b. COUNTY by the f Pages 1 urs after 600 CAR MARYLANO b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) hours hours .= bon papers. within 72 ho d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) filled d. STREET AOORESS e. IS RESIDENCE ON A FARM? 24 NOR YES r and completely i remove carbon p. within 3. NAME OF First Middle Last DATE Month 0ay Year DECEASED (Type or print) DEATH 196 executed SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 7. MARRIED 8 9. NEVER MARRIEO last birthday) Months I Days Hours WIDOWED DIVORCED physician and ph 10a. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT pe during most of working life, even if retired) INDUSTRY COUNTRY3. OUSENI 0 death certificate 13. FATHER'S NAME MOTHER'S MAIDEN NAME attending ph ermit. Then remova the attend it permit. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT 17. 0 (Yes, no, or unkown) (If yes give war or dates of service) cremation, been signed by the stransit price to burial, cremati INTERVAL BETWEEN ONSET AND DEATH CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Page 4 may be retained by the hospital or attending physician. IMMEDIATE CAUSE (a) 4200 **OUE TO** Conditions, If any, which gave rise to immediate OUE TO cause (a), stating the as th underlying cause last. After this certificate has (c) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY for use Health use PERFORMEO? YES NO 20a. ACCIDENT WAS UNDERLYING DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) detached f OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State) (County) be de State factory, street, office bldg., etc.) Hour a.m. While Not While p.m at work at work P DIRECTOR: Jage 3 should filed with the the 196 21. I certify that (I) (this hospital) attended the deceased from that (I) (we) last saw the deceased alive on. and that death occurred at. M. from the causes and on the date stated above. 22a. SIGNATURE 22b. OATE SIGNED MEO. ATTENOING PHYS. DIRECTOR pa TO FUNERAL PHYSICIAN'S 22d. ADDRESS 22c. director, p NAME (Type) BURIAL, CREMATION, 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) FUNERAL OIRECTOR ADDRESS REC'O BY REGISTRAR 25b. REGISTRAR'S VR A15 (4) 20M 1/65



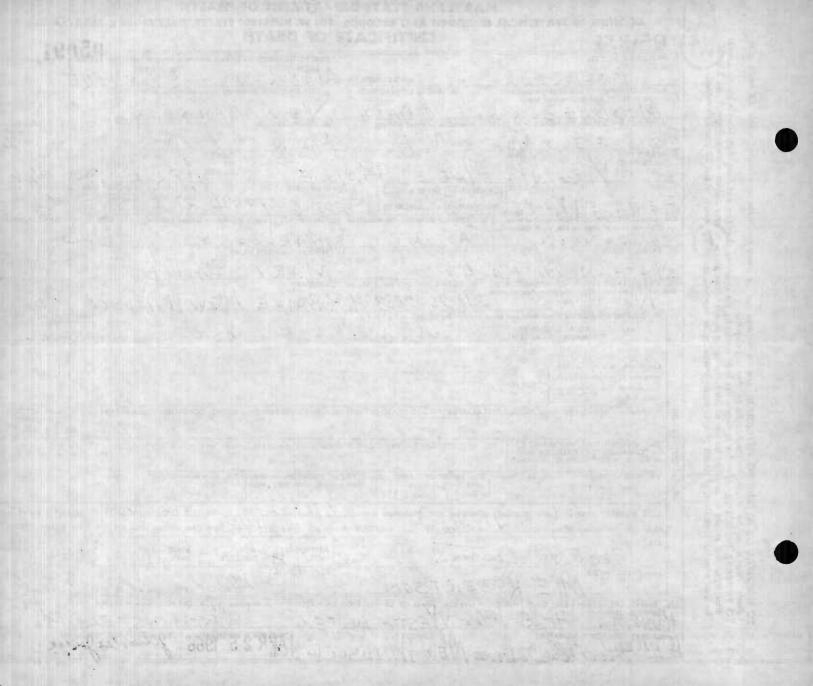
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12	FATHER'S NAME	housew	rife		o., Marylan	d U.S.	Α.
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MAKTLAND STATE DEPARTMENT OF HEALTH

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH Should funera PLACE OF DEATH 2. USUAL RESIDENCE (Whara dacaasad lived, If Institution: within 24 hours a. COUNTY by the and 2 death. COUNTY MARYLAND 6 b. CITY OR TOWN (if outside corporate limits, P c. LENGTH OF STAY IN 1b OR TOWN (If outside corporate limits, RURAL and give neerest town) rije RURAL end give neerest town) .= Pages d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) filled papers. Page n 72 hours a REET ADDRESS e. IS RESIDENCE ON A FARM? completely YES NO IP 3. NAME OF DATE Month Dey Yeer DECEASED OF DEATH (Type or print) 19 and cor withi 5. SEX AGE (In yeers | IF UNDER 1 YEAR AF UNDER 24 HRS 7. MARRIED NEVER MARRIED birthdey) Months Deys Hours certificate WIDOWED X DIVORCED ahysician 10e, USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? foreign country) during most of working life, even if retired) 13. FATHER'S NAME MOTHER'S MAIDEN NAME ding 0 aften WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 17. INFORMANT (If yes give wer or detes of service) CAUSE OF DEATH [Enter only one cause per line for (e), INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 222 DUE TO Conditions, if any, which (b) geve rise to immediate cause DUE TO (e), steting the underlying cause lest. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) 19. WAS AUTOPSY as 0 CERTIFICATION PERFORMED? use prior YES NO T for 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter neture of injury in Pert I or Pert II of item 18.) Heelth detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm, ! 20f. (City or town) (County) (Stete) ō fectory, street, office bldg., etc.) Hour a.m. While Not While DIRECTOR: at work at work 19 p.m. 21. I certify that (I) (this hospital) attended the deceased from......// 1.4.4 19 that (1) (we) Tast plnods 22e. SIGNATURE DATE 22b. ATTENDING STAFF SIGNED eth. Page 4 HOSPITAL page with th DIRECTOR PHYS. PHYS. M.D. 22c. PHYSICIAN'S 22d. ADDRESS filed , NAME (Type) 23d. LOCATION (City, town or county) (Stete) 23a. BURIAL, CREMATION, 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23c. 0.58 Ö REMOVAL (Specify) FUNERAL DIRECTOR'S SIGNATURE 25bacREGISTRARIS SIGNATURE VR A1S (4) 20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH





ALTIMORE, MARYLAND 21201

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 050952. USUAL RESIDENCE (Where deceased lived. If institution, Residence before edmission 1. PLACE OF DEATH a. COUNTY b. COUNTY Carroll Carroll Maryland MARYLAND b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL end give neerest town) write RURAL and give nearest town) Finksburg Finksburg 20 years IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS ON A FARM? School House Lane School House Lane YES NO TO 3. NAME OF 4. DATE Middle DECEASED (Type or print) Albert W. DEATH Bean 19 66 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Hours Male DIVORCED T WIDOWED 10a. USUAL OCCUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) done during most of working life, even if retired Carroll Co.. Md. U.S.A. Laborer 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Savilla Warfield George T. Bean 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | (Ifyesgive wer or dates of service) Mrs. Earl F. Mann Finksburg, Md. No None INTERVAL BETWEEN 18. CAUSE OF DEATH Enter only one cause per line for (e), (b), end (c).] ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Bronchial Pneumonia IMMEDIATE CAUSE (a) DUE TO Conditions, if env. which geve rise to immediate cause DUE TO (e), steting the underlying Arteriosclerotic C.V. Disease vears PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO TO Gastric ulcer 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Part I or Part II of item 18.) 20a. ACCIDENT WAS UNDERLYING IT OR CONTRIBUTING CAUSE OF DEATH (State) 20c. TIME OF INJURY Month, Day, Yeer 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, ferm, 20f. (City or town) (County) fectory, street, office bldg., etc.) Not While Hour e.m. at work et work 21. I certify that (I) (this hospital) attended the deceased from Sept. 28 , 19.50 to April 22, 19.6 (that (I) (we) last saw the deceased alive on....April 20.19.66., and that death occurred at... PM, from the causes and on the date stated above. 22b. DATE 22a SIGNATURE SIGNED ATTENDING DIRECTOR PHYS. M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) E. Strobel, M.D. Main St. Reisterstown, Maryland 23d. LOCATION (City, town or county) (Stete) 23c. NAME OF CEMETERY OR CREMATORY 23a, BURIAL, CREMATION, | 23b. DATE THEREOF REMOVAL (Specify)
Burial Deer Park Methodist Cem. Reisterstown. Md. 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS A15 Westminster. Md. 15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05096 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY b. COUNTY. Carroll papers. Pages I hin 72 hours after MARYIAND b. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town)
Rural -- Sykesville c. CITY DR TDWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH DE STAY IN 16 days Sitestille 151 W. All Saints St. e. IS RESIDENCE d. NAME OF HDSPITAL DR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS ON A FARM? Springfield State Hospital Frederick YES ND 3. NAME OF Middle Lost 4. DATE Day First Month Year DECEASED Carrie Amelia Bentley April 30 14166 DEATH IF UNDER 1 YEAR S. SEX 6. COLOR OR RACE B. DATE OF BIRTH AGE (In years 7. MARRIED NEVER MARRIED buriol, cremation, or removal, and in any ev 86 birthday) Mar. 25,1880 female Negro WIDOWED DIVORCED 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) COUNTRY? during most of warking life, even if retired) INDUSTRY Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Susan Skinner James Bentley 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY ND. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) Springfield Hospital Records, Sykesvill E, MC INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for, (o), (b), and (c).) TONSET AND DEATH buriol-transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) signed by DUE TO ERICTIC HEART DISEX Conditions, if ony, which gove rise to immediate cause (a), DUE TD stating the underlying cause this certificate has been for use as the WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NDT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES 🔀 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 of Part 1 af item 1B.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED foctory, street, affice bldg., etc.) Nat While at work 21. I certify that M (this haspital) attended the deceased fram 4-22-, 1966, to 190, that M (we) last saw the deceased alive an 4-30- 1966, and that death accurred at 270M, fram causes and an the date stated above. 220. SIGNATURE 22b. DATE SIGNED Springfield State Hospit A 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) ykesville, Md. 23o. BURIAL CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify)
Burial 5/3/66 Frederick Frederick, Md 0 Fairview 2Sb. REGISTRAR'S SIGNATURE 2Sa. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR C.E. Hicks.

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requires that the death certificate be executed within 24 haurs after death

ATTENDING PHYSICIAN: The

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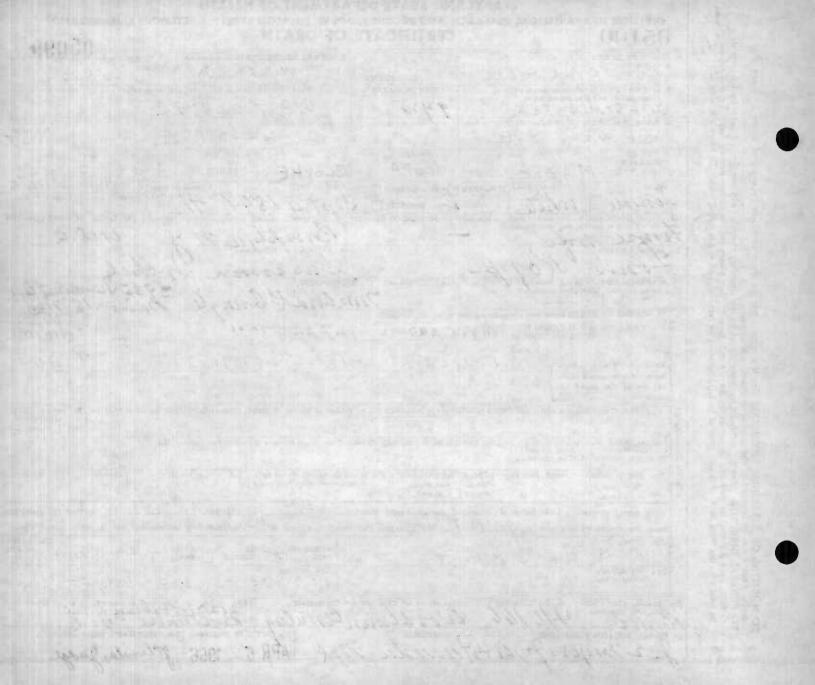
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05099 CERTIFICATE OF DEATH death, be executed within 24 haurs after death and campletely filled in by the funeral remove carban papers. Pages 1 and in any event, within 72 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH o. COUNTY a. STATE b. COUNTY Carroll MARYLAND Maryland Montgom
c. CITY OR TOWN (If auliside carparate limits, write RURAL and give nearest town) Montgomerv c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Silver Spring 6mo 18da Sykesville d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? and in any event, within 72 1312 Dennis Ave. Springfield State Hospital YES NO 3. NAME OF 4. DATE Lost Month Day Year DECEASED April 1966 (Type or print DEATH James Meredith S. SEX AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthday) Manths Days Hours 2-27-78 Male White WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind af wark dane 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT attending plysician permit. The please during most of working life, even if retired) INDUSTRY COUNTRY? Virginia requires that the death certificate U.SA. Farmer 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar removal, Not Known Catherine AddressSykesville 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, na, ar unknawn) (If yes give war or dates af service) 16. SOCIAL SECURITY NO. 17. INFORMANT permit. Maryland 223-03-6053 No Springfield Hosp, Records 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Arteriosclerotic Cardio—vascular disease INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH IMMEDIATE CAUSE (o) Beginning gangrene DUE TO Weeks Conditions, if ony, which gove rise to immediate cause (o), DUE TO Advanced Generalized Arteriosclerosis TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital ar attending TO FUNERAL DIRECTOR: After this certificate has been as the stating the underlying couse Years last. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT COMPUTIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) detached far use te Dept. af Health p CERTIFICATION Chronic Brain Syndrome Associated with Cerebral Arterioscler ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NO cerebral Arteriosclerosis YES 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Day, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or tawn) (County) (Stote) Hour o.m. factory, street, affice bldg., etc.) Not While the State at work at work 3 shauld be to 11-16-66, 19_, that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased fram 10-28-63.19 and that death accurred at 8:45AM, from causes ond on the date stated above. saw the deceased alive on. 22a. SIGNATURE 22b. DATE SIGNED MED. DIRECTOR STAFF PHYS. ATTENDING 4-16-66 director, page 3 should be filed v PHYS 22d ADDRESS Antonius Glahn, 22c. PHYSICIAN'S Sykesville, Maryland NAME (Type) 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY (County) 23o. BURIAL, CREMATION, 23b. DATE THEREOF (State) REMOVAL (Specify) X100exington UFIA ADDRESS 24. FUNERAL DIRECTOR VR A15 (4)

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DIVISION OF STA	MARYL TISTICAL RESEAR	AND STATE DEP	ARTMENT OF	HEALTH STREET, BALT	IMORE 1. MA	RYLAND
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d. NAME OF HOSPITAL OR	A	spital, give street eddress)	d. STREET ADDRESS	ARD AU	6	e. IS RESIDENCE ON A FARM?
3. NAME OF DECEASED	First	Middle	Last	4. DATE	Month	Day Yeer
(Type or print) MA	ZIE	KOPP	BLOCHE	DEATH	APRIL	3 1966
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Well.	rin I Slee	rut "	.D. PHYS.	MED. STA		4/3/66 SIGNE
22c. PHYSICIAN'S NAME (Type)		/	19 RIDG	ERD, U	JESTMINS	TRR, MD,
23a. BURIAL, CREMATION, 23	b. DATE THEREOF	23c. NAME OF CEMETERY	OR CREMATORY	23d. LOCATION	(City, town or county	Enie (State)
24 FUNERAL DIRECTOR'S SIGN	ATURE_	ADDRESS	250 RE	C'D BY REGISTRAR	25b. REGISTRAR'S	SIGNATURE
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TON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral after PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) . COUNT hours the d 2 and 2 death. MARYLAND b. CITY OR TOWN (if outside corporale limits, c. LENGTH OF STAY IN 16 write RURAL and give nearest lown write RURAL and give neerest town) Pages 1 after .⊑ NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) within filled e. IS RESIDENCE hours ON A FARM? NO I YES T papers. n 72 hor completely NAME OF DECEASED 4. DATE Month Day OF (Type or print) DEATH = 19 pou withi S. SEX COLOR OR IF UNDER 24 HRS. AGE (In yeers | IF UNDER 1 YEAR 9. 7. MARRIED NEVER MARRIED and last birthdey) Months Deys Hours MIn. event, WIDOWED IV DIVORCED physician USUAL OCCUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY 10b. KIND OF BUSINESS OR INDUSTRY please remov done during most of working life, even if retired FATHER'S NAME 2 aftending WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT removal (Yes, no, or unkown) | (If yes give wer or detes of service) the permit. affending physician. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).] INTERVAL BETWEEN ONSET AND DEATH may be retained by the hospital or attending physician DIRECTOR: After this certificate has been signed by ö I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) cremation, burial-transit Conditions, if any, which geve rise to immediate cause DUE TO burial, (e), stating the underlying couse lest. the (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) 19. WAS AUTOPSY CERTIFICATION use as r PERFORMED? NO X prior 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter neture of injury in Pert I or Pert II of item 18.) for Health (IF EITHER, NOTIFY MEDICAL EXAMINER) detached MEDICAL 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED I 20e. PLACE OF INJURY (Home, farm,) 20f. (€ity or town) (County) (State) factory, street, office bldg., elc.) Hour e.m. While Not While ō et work et work 19 21. I certify that (1) (this hospital) attended the deceased from. 41 M, from the saw the deceased alive on... causes and on the date stated above. 22e. SIGNATUR 22b. DATE ATTENDING MFD. STAFF SIGNED death. Page 4 i DIRECTOR PHYS. PHYS. M.D. HOSPITAL page with th 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) filed v 258. BURIAL, 23Ь. DATE THEREOF NAME OF CEMETERY OR CREMATORY (Stete) CREMATION, 23c. LOCATION (City, town or county) REGISTRAR REC'D BY 25b. REGISTRAR'S SIGNATURE 20M 5-63

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 05102CERTIFICATE OF DEATH funeral hours after death PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY a. STATE b. COUNTY filled in by the fu papers. Pages 1 hin 72 hours after MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mf outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? NO YES completely twee carbon p death certificate be executed within 3. NAME OF Month Day First Middle DATE Year DECEASED 8 1966 (Type or print) DEATH 5. SEX DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. | Iast birthday) | Months | Days | Hours | Min. 6. COLOR OR RACE 7. MARRIED 8. NEVER MARRIED remon WIDOWED DIVORCED lease re and In 10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR (County & State, or foreign country) 12. CITIZEN OF WHAT 11. BIRTHPLACE during most of working life, even if retired) COUNTRY? INDUSTRY 11.50 FATHER'S NAME MOTHER'S MAIDEN NAME or removal 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or uniform) ((If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address has been signed by the atten as the burial-transit permit. prior to burlal, cremation, or i Same 20-INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] The law requires that the or attending physician. ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO resenten: Conditions, if any, which (b) gave rise to immediate DUE TO (a), stating the underlying cause last has (c) CERTIFICATION WAS AUTOPSY detached for use a PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) PERFORMED? YES NO L PHYSICIAN: T the hospital of DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part for Part II of Item 18.) 20a. ACCIDENT WAS UNDERLYING F OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL TIME OF INJURY Month, Day, Year 20e. PLACE OF INJURY (Home, farm, (County) (State) 20d. INJURY OCCURRED 20f. (City or town) factory, street, office bldg., etc.) ø Hour a.m. While Not While TO FUNERAL DIRECTOR: After director, page 3 should be calculd be filed with the State ATTENDING be retained by 19 at work at work 19=3 1964, that (I) (we) last 26 21. I certify that (I) (this hospital) attended the deceased from and that death occurred at 8 3 66 M, from the causes and on the date stated above. saw the deceased alive on. DATE SIGNED 22a. SIGNATURE 22b. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. M.D. Page 4 may 1 22c. PHYSICIAN'S 22d. **ADDRESS** NAME (Type) HARSHEY WESTMINSTER ANCHOR 57. M.D. LOCATION (City, town or county) (State) BURIAL, CREMATION, 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) REC'D' BY REGISTRAR FUNERAL DIRECTOR VR A15 (4) 15M 4-64

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	h ce tendi nit.	WAS DECEASED EVER IN U.S. ARMED FDRCES? 16. SDCIAL SECURITY NO. 17. INFORMANT AI , no, or unknown) (If yes give war or dates of service)	ddress
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	The law requires that the death certificate be estending physician. Sate has been signed by the attending physician are as the burial-transit permit. Then please realth prior to burial, cremation, or removal, and in	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOS ELERATIC CARLIB WAS CHAR LISERSE	INTERVAL BETWEEN DNSET AND DEATH
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	g ph g ph en si e bur o bur	conditions, if any, which gave rise to immediate (b) PERIPHERAL ARTERIOSCLERESIS	YEARS
	ndin ndin s be s the ior t	cause (a), stating the DUE TD underlying cause last. (c)	
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		20c. TIME OF INJURY Month, Day, Year 20d. INJURY DCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or tow factory, str	n) (County) (State)
	rending pained by the OR: After tould be dithe State	21. I certify that (I) (this hospital) attended the deceased from 3-1-56, 19, to 1-29-	66 19 that (I) (we) last
	ATTENDING retained by CTOR: After should be vith the Stat	saw the deceased alive on 4/19 1966, and that death occurred at 150M, from the cau	ses and on the date stated above.
	d v d	22a. SIGNATURE PO Wise M.D. ATTENDING MED. STAFF PHYS.	22b. DATE SIGNED
	Page 4 may 10 FUNERAL D director, pag should be file	22c. PHYSICIAN'S NAME (Type) C	State Hospital
	TO HOSPITAL Page 4 may O FUNERAL director, pa		Maryland 21781 ₁ ty, town or county) /(State)
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1 8	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
# E0# #	05104 CERTIFICATE OF DEATH
24 hours after death. filled in by the funeral apers. Pages 1 and 2 nn 72 hours after death.	1. PLACE OF DEATH a. COUNTY Carroll MARYLANO 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) b. COUNTY b. COUNTY
in by the	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
hou hou st ir.	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS 6. IS RESIDENCE
	Springfield State Hospital Argyle Avenue
executed within 24 hours after and completely filled in by the remove carbon papers. Pages 1 any event, within 72 hours after	3. NAME OF DECEASED (Type or print) JAMES CHRISTOPHER CARTER DEATH 4 29 19 66
uted wi I comple ove cart y event,	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR FUNDER 24 HRS.
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uires that the dea g physician. nn signed by the a burial-transit per burial, cremation	PART I. DEATH WAS CAUSED BY: A RTERIOSE PRACTIC CARDIO MASCULAR DISEASE 13 days
ysici gne ial-t	4 2 2 1 OUE TO
s ph s ph pur bur	Conditions, If any, which (b) (b)
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law reattendir has be e as th	
The or a	Chronic brain syndrome associated with cerebral arteriosclerosis YES NO NO
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attendirector, page 3 should be detached for use as the burial-transit permit should be filed with the State Dept. of Health prior to burial, cremation, or	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO OEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? Chronic brain syndrome associated with cerebral arteriosclerosis 20a. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF OEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. OESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
PHYS the I r this detac detac	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hour a.m.
d by Afte Star	
TTEND etaine TOR: should	21. I certify that (this hospital) attended the deceased from 4-16, 19 66, to 4-29, 19 66, that (1) (we) last saw the deceased alive on 7/29, and that death occurred at 2:34M, from the causes and on the date stated above.
DOR JOR W	22a. SIGNATURE 22b. DATE SIGNED M.O. PHYS. DIRECTOR PHYS. 22b. DATE SIGNED 4-29-66
AL DIR page filed	22c. PHYSICIAN'S L 22d. ADDRESS
SPIT 4 r NER/ Stor,	NAME (Type) Sam P. Wise III Springfield State Hospital
Page TO FU direc shoul	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY / 23d. LOCATION (City, town or county) (State) Sharp Street., / Sandy Spring, Md.
VR A15 (4)	24. FUNERAL DIRECTOR ADDRESS JOSE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
20M 1/65	MAY 3 1966 Acharles Judge

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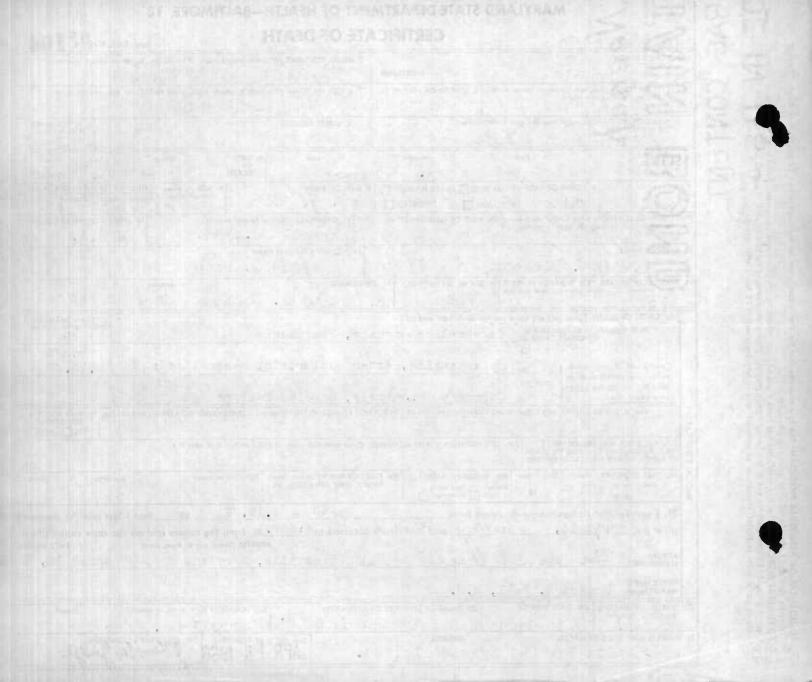
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE	OF	DEAT
CERTIFICATE	UF	DEAL

Reg. Dist. No. () 5104

PLACE OF DEATH O. COUNTY Ca	rroll		MAR	RYLAND	l o. STATE	DENCE (Whe		d lived. If institut	tion: Reside	-	odmissio	on)
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OR INSTITUTION	AL (If not in hospital, g				d. STREET A						IS RESIL	FARM?
Pullen					nou	00 1					YES 🗌	NO 🗆r
3. NAME OF DECEASED (Type or print)	Fir Lu		Midd A e		los onaway	t	4. DATE OF DEATH		oril	13 a		966
5. SEX	6. COLOR OR RACE	7. MARR	IED MEVER MARI	RIED 🔲	B. DATE OF BIRTH			9. AGE (In years lost birthdoy)		R 1 YEAR I	-	
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Housewi 13. FATHER'S NAME	ing life, even if retired		KIND OF BUSINESS	OR INDU	Carre	oll (ZO • 9	Md.		U.S.		COUNTRY?
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(Yes, no. or unknown)	(If yes, give wor or dates of s	rvice	None		. Arthu	r R.	Cons		ame .	As A	bove	9
	TH [Enter only one co TH WAS CAUSED BY: IMMEDIATE CAUSE (o	0-2	e for (o), (b), and (orebral hem		age, Hem:	iplegi	a			ONSE	VAL BETY T AND E 965	WEEN
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OR CONTRIBUTING	S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRIBE HOW INJURY	OCCURRE	D. (Enter nature o	f injury in Po	ort I or Par	t 11 of item 18.)				
Y 20c. TIME OF INJURY Hour a. m. p. m.	Y Month, Doy, Yes	While of worl	Not while of work		ACE OF INJURY (I ctory, street, office	bldg., etc.)				(County)		(Stote)
21. I certify the alive an Apr	at 1 attended the il 13,		ed from. 66, and the		occurred at	4:50P.	M, frai	m the causes treet, city or town ryland	and an	last sav	state: DA	deceased d abave. TE SIGNED 4, 19
	loward E. H											
270. BURIAL, CREMATION REMOVAL (Specify) Burial	4/16/19	966	Winfiel	an arthurst	urch 01	Cem.	~	TION (City, town, roll Co	or county)	aryl	(Stote)	
23. FUNERAL DIRECTOR	tz Box 21	-1 S	ADDRESS ykesvill	e, M	ld e	DATE R	BY REGIST	966 24b. REG	land	GNATURE LA	ye.	



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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 23 Film G375 4/21/66 mh CERTIFICATE OF DEATH 05107 the funeral ages 1 and 2 rs after death requires that the death certificate be executed within 24 haurs after death. 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH b. COUNTY o. COUNTY a. STATE Maryland Carroll MARYLAND signed by the attending physicial and campletely filled in by the fur burial-transit permit. Then please above carban papers. Pages I burial, crematian, ar removal, and in any event, within 72 haurs after c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21205 6 mos Baltimore Svkesville e. IS RESIDENCE ON A FARM? filled in I d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS 3203 McElderry Street Springfield State Hospital NO IX 4. DATE Year 3. NAME OF First Middle Last Doy DECEASED 1966 DIEGELMAN April 8 John Henry DEATH (Type ar print) IF UNDER 1 YEAR IF UNDER 24 HRS. AGE (In years B. DATE OF BIRTH S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthday) Months Doys Hours 11-19-1894 white WIDOWED DIVORCED male 12. CITIZEN OF WHAT 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 10o. USUAL OCCUPATION (Give kind of work done COUNTRY? during most of working life, even if retired)
Paperhanger INDUSTRY Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Christine Offenstein Anthony Diegelman 17. INFORMANT 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor ar dates of service) Springfield State Hospital Records INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) ONSET AND DEATH PART I. DEATH WAS CAUSED BY RONCHOPNEUM ON 14 IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physician. DUF TO Conditions, if any, which gave (b) rise ta immediate cause (a), DUE TO stoting the underlying couse d far use as the af Health priar ta TO FUNERAL DIRECTOR: After this certificate has been lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT_CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature af injury in Port 1 ar Part II af item 1B.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) directar, page 3 shauld be detache shauld be filed with the State Dept. (City or town) (Stote) (County) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. 20c. TIME OF INJURY Manth, Day, Year factory, street, affice bldg., etc.) Hour a.m. Nat While ot work ot work 21. I certify that (1) (this hospital) attended the deceased from 10-9-62 _, 1966, that (1) (we) last 1966, and that death accurred at 200 M, fram causes and an the date stated above. saw the deceased alive an 220. SIGNATURE 22b. DATE SIGNED DIRECTOR > M.D. 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN Robert N. Deeb, M.D. Sykesville. Maryland NAME (Type 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Caunty) (Stote) 23b. DATE THEREOF 23a. BURIAL, CREMATION, REMOVAL (Specify) Holy Redeemer Baltimore, Md. 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66

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7	1(M)	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET,	BALTIMORE 1. MARYLAND
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d d	Sicia	ng most of working life, even if retired) INDUSTRY Maryland	U.S.A.
100	physi n	FATHER'S NAME 14. MOTHER'S MAIDEN NAME	0.0.7.
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The law requires that the death certificate he	d by the at ransit perm cremation,	18. CAUSE OF OEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY:	INTERVAL BETWEEN ONSET AND DEATH
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- de	al or al ficate for use Health	psychotic reaction.	YES NO
PHYCICIAN.	the hospital or this certificate detached for use e Dept. of Health	20a. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	or Part II of Item 18.)
IV	this this letach Dept	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City	y or town) (County) (State)
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ATTENDING	3 = = 5		1-11-66, 19, that (I) (we) last
	Sho sho ith t		the causes and on the date stated above
2	be seed y	22a. SIGNATURE Delication Director Dir	STAFF PHYS. 14-14-66
O HACPITAL	Page 4 may be retained by FUNERAL DIRECTOR director, page 3 should be filed with the	22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS Springfie	old State Hospital
HOCH	Page 4 m FUNERA director, should be		e, Maryland 21784 TION (City, town or county) (State)
5	T in the	DEMOVAL (encelfu)	more, Maryland
	Ko		AR 25b. REGISTRAR'S SIGNATURE
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05109 requires that the death certificate be executed within 24 hours after death death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) campletely filled in by the funeral ave carban papers. Pages 1 and PLACE OF DEATH o. COUNTY Carroll ve carban papers. Pages I event, within 72 haurs after MARYLAND No fixed address b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn)

Sykesville c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) 1 mo. 2 dys. No fixed address d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital YES NO EX 3. NAME OF Middle 4. DATE First Last Manth Day Year DECEASED (NMN) JOSEPH ETON April 9 66 19 Type or print DEATH IF UNDER 24 HRS. IF UNDER 1 YEAR S. SEX 6. COLOR OR RACE B. DATE OF BIRTH AGE (In years 7. MARRIED NEVER MARRIED Gast birthday) Manths 10-18-1899 Days Haurs Male White WIDOWED 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT COUNTRY? INDUSTRY Massachusetts Unknown 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME crematian, ar remaya Unknown Unknown 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, na, ar unknawn) (It yes give war or dates of service) Ukenown Records, Springfield State Hospital 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), ond (c).)
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	T 0.= / /	43 JOHN STREET 43 JOHN STREET VES NO NO NA FARMS
		3. NAME DF First Middle Last 4. DATE Month Day Year DECEASED (Type or print) ROY CHARLES CAMBER DEATH APRIL 15 1966
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	OR ATTEN be retain DIRECTOR: ge 3 shou led with th	22a, SIGNATURE // 22b. DATE SIGNED
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	HOSPITA age 4 ma FUNERAL irector, p	22c. PHYSICIAN'S NAME (Type) WILLIAM R. O'ROURKE 150 W. MAIN ST. WESTHINSTERM
	TO HOSPITAL Page 4 may TO FUNERAL director, pa	23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
	nl	ADDRESS 25a. PÉC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05111 requires that the death certificate be executed within 24 hours after death by the funeral Pages 1 and 2 deoth PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY ve carbon papers. Pages 1 event, within 72 hours after Carroll MARYLAND Marvland Baltimore City c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest lawn) b. CITY OR TOWN (If autside carporate limits, write RURAL and give neorest town) c. LENGTH OF STAY IN 1b. Baltimore 6vrs.6mos.12dvs Svkesville d. STREET ADDRESS e. IS RESIDENCE ON A FARM? .⊑ d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) filled 5905 Kayon Avenue Springfield State Hospital YES NO DE 3. NAME OF Middle 4. DATE pase remove carbon Lost Doy Year completely DECEASED GOLDERMAN 14 AUGUSTA MMN APRIL 66 19 (Type or print) DEATH IF UNDER 24 HRS. IF UNDER 1 YEAR S. SEX DATE OF BIRTH AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthdoy) Months Doys Hours and in any e 2-1-1874 Female White WIDOWED DIVORCED and 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) U.S.A. INDUSTRY ottending physicion permit. Then planse Unk. Housewife 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 0 30 crematian, or remova John H. Lenhart Unk. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. permit. (Yes, no, or unknown) (If yes give wor or dotes of service) Unk. Records, Springfield State Hospital INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the burial-transit p PART I. DEATH WAS CAUSED BY ONSEL AND DEATH Arteriosclerotic heart disease ears IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove Generalized arteriosclerosis Years (b) rise to immediate couse (a). DUF TO stoting the underlying couse as the has been lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

CBS assoc. with cerebral arteriosclerosis, with psychotic reaction 19. WAS AUTOPSY PERFORMED? for use NO X Page 4 moy be retained by the hospitol or FUNERAL DIRECTOR: After this certificate irector, page 3 should be detached for us 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (Stote) 20c. TIME OF INJURY Month, Doy, Year (County) Hour o.m. foctory, street, office bldg., etc.) Not While ot work ot work 21. I certify that (1) (this hospital) attended the deceased from 10-2-59 4-14-66, 19___, that (1) (we) last director, page 3 should should be filed with the and that death accurred of 11:50%. From causes and on the date stated above. 4-14-66 saw the deceased olive an-19 22b. DATE SIGNED 22o. SIGNATURE ATTENDING MED. DIRECTOR 4-14-66 M.D. PHYS. PHYS 22d. ADDRESS Springfield State Hospital AZC. PHYSICIAN'S NAME (Type) Agustin del Campo M. D. Sykesville, Maryland 230. BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) 4/16/1966 Loudon Park Cemetery Baltimore, Maryland 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4)

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1 1/2	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYL	AND
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y the sit is mati	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY:	RVAL BETWEEN ET AND DEATH
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PHYSICIAN: The law requires that the death certificate be the hospital or attending physician. This certificate has been signed by the attending physician detached for use as the burial-transit permit. This please to Dept. of Health prior to burial, cremation, of removal, and i	Conditions, if any, which) (b) In the fractical hemosphage 2	o minal
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y be DIRE	Same Checking M.D. ATTENDING MED. STAFF 4. 19	,66
TO HOSPITAL OR Page 4 may be for FUNERAL DIRR director, page should be filed to	22c. PHYSICIAN'S NAME (Type) Sani Okutman 22d. ADDRESS Sykesville,	ud.
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2 2 0	BURIA! 19-21-66 OHK Grove Cemetery! Howard Co.	Md.
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I	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
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JING PI d by th After t d be de s State	
Per e	21. I certify that (1) (this hospital) attended the deceased from 1966, and that death occurred at 8.36 M, from the causes and on the date stated above
ш со ≤	22a. SIGNATURE 1 / 22b. DATE SIGNED
	M.D. ATTENDING MED. STAFF DIRECTOR DIRECTOR PHYS. DI 4/4/66
	122c. PHYSICIAN'S NAME (Type) Wx H FOARD M.D 22d. ADDRESS NAME (Type) Wx H FOARD M.D MANCHESTER MA
Page 4 r. Property Page 4 r. Pro	3a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
2-2-16	Burial 4/6/66 Immanuel Cemetery Manchester Md. ADDRESS 1252. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
VR A15 (4)	Tipton-Eline Fun. Home, Hampstead, Md. DATAPR 7' 1966 gcharles Judge

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 24 hours after PLACE OF DEATH 2. USUAL RESIDENCE (Whara deceased lived, If institution: Residence before admission, a. COUNTY Baltimore 17 Pe Carrol Marvland MARYLAND and b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearast town) -hours after Pages Svkesville vears Baltimore 2 within filled d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS . IS RESIDENCE ON A FARM? Pullen Nursing papers. n 72 hou completely 1724 Glen Curtis YES NO 3. NAME OF Middle 4. DATE Month Year DECEASED OF (Type or print) DEATH 1966 rbon Luther Holt. Apri 7 5. SEX 6. COLOR OR RACE 7. MARRIED X NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Male death certificate WIDOWED [attending physician 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY done during most of working life, even if retired) Sanitation Martin Frederick Co.. U.S.A. Md. Dent. please 2. 13. FATHER'S NAME pue Charles Holt Lucinda Stottlemver Then 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | (Ifyesgive war or detes of service) alto. law requires that permit. the hospital or attending physician. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). has been signed by INTERVAL BETWEEN ŏ ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Diabetes, severe: Caronary thrombosis: cremation, IMMEDIATE CAUSE (a) 1965 burial-transit DUE TO through Cardiac failure: Pneumonia: Conditions, if any, which April 17 gave rise to immediate cause DUE TO 1966 (a), stating the underlying the Cerebral vascular accident. DIRECTOR: After this certificate PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) detached for use as 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO J 2Da. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH 20c. TIME OF INJURY Month, Day, Yaar 2Dd. INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, ! 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. While Not While at work at work p.m. Pe 21. I certify that (I) (this hospital) attended the deceased from. 1965, 19 ..., to April 17 ..., 1966, that (I) (we) last pinous 22a. SIGNATURE Page 4 TO FUNERAL director, page 3 be filed with the ATTENDING SIGNED HOSPITAL PHYS. DIRECTOR PHYS. April 18. 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) Howard E. Hall. M.D. Sykesville. Maryland 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) REMOVAL (Spacify) Frederick 24 FUNERAL DIRECTOR'S SIGNATURE Waltz Box 241 Sykesville, Md. VR A15 (4)

RYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05116 CERTIFICATE OF DEATH and 2 requires that the death certificate be executed within 24 haurs after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission physician and campletely filled in by the funeral en please tenove carban papers. Pages 1 and o. COUNTY/ b. COUNTY MARYLAND b. CITY OR TOWN (If outside carparate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If estside carporate limits, write RURAL and give nearest town) write RURAL and give nearest town) papers. hin 72 ha e. IS RESIDENCE ON A FARM? d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 60 NO 4 YES 3. NAME OF Middle 4. DATE Month First Lost Doy Year DECEASED OF DEATH 19 (Type or print) 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH lost birthdoy) Months Hours Dovs WIDOWED DIVORCED 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, every if retired) COUNTRY? INDUSTRY 1-lares 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 16. SOCIAL SECURITY NO WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) INTERVAL BETWEEN ransit ONSET, AND DEATH PART I. DEATH WAS CAUSED BY: signed by 1 IMMEDIATE CAUSE (o) DUE TO burial-t Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse **DIRECTOR:** After this certificate has been the WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO P YES the haspital ar ar 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (Stote) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) 20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. Not While foctory, street, office bldg., etc.) ot work ot work 21. I certify that (1) (this haspital) attended the deceased fram affice 6 , 1966, to april _____, 1964, that (I) (we) last be retained 19.66, and that death accurred at 2 5 M, from causes and an the date stated above saw the deceased alive an 22b. DATE SIGNED 22o. SIGNATURE M.D. DIRECTOR PHYS. PHYS. 22d. ADDRESS 22c. PHYSICIANS O FUNERAL NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Lown) (Stote) 23o. BURIAL, CREMATION, 23b. DATE THEREOF (County) REMOVAL (Specify) FUNERAL DIRECTOR **ADDRESS** 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4)

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ing d to	5 5	20a EXTERNAL CALISE WAS 1.20b DESCRIBE HOW INITIRY OCCURRED (Enter nature of Indury In Part 1 or Part 11 of Item 18.)	0
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forw	agent, pri	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 12: 45 p.m. 4/2 19 66 While at work at work at work at work Sykesville Carroll Md.	e)
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cute the cage 4 should report files.	desi	death resulted from: Natural causes, Accident X, Suicide , Homicide , Undetermined manner CHIEF MEDICAL EXAMINER	
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DEP please direct retain		REMOVAL (Specify)	,
		24. FUNERAL DIRECTOR // ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
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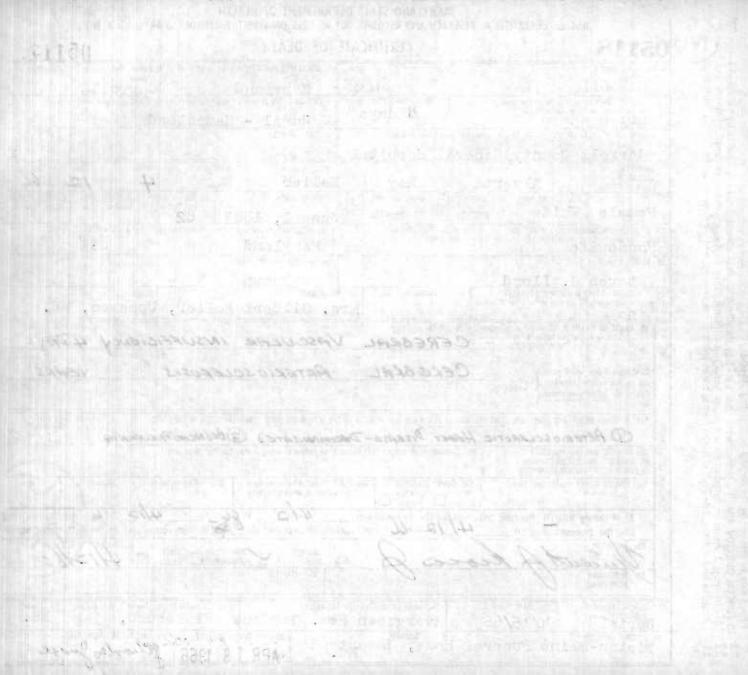
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TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physicion-and completely filled in by the funeral director, page 3 should be detached for use as the buriol-transit permit. Then pleas reprove corban papers. Pages 1 and 3 should be filed with the State Dept. af Health priar to buriol, cremation, or removol, and in any event, within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH

		Divisian af STATISI	TICAL RESEA	RCH AND RECOR	RDS, 301	W. PRESTON STR	EET, BALTIMOR	RE, MARYLA	ND 21201	
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L	BURIAL, CREMATIC BURIAL (Specify)	4/15/	66		en M	em. Garde	ns Fin	N (City or Town	g,	Md.
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 051 CERTIFICATE OF DEATH funeral and 2 r death 24 hours after death. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence Before numission) a. COUNTY b. COUNTY rbon papers. Pages 1 and within 72 hours after c MARYLAND b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write BURAL and give neavest town) write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address; d. STREET ADDRESS etely rbon p NAME DE Middle DATE Month 4. DECEASED OF car (Type or print) DEATH 5. SEX CDLOR OR RACE DAJE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 7. MARRIED NEVER MARRIED remove last birthday) | Months | any and WIDOWED X DIVORCED Q yrs. 10b. KIND OF BUSINESS OR INDUSTRY physician an please ro Ξ 10a. USUAL OCCUPATION (Give kind of work done | BIRTHPLACE (County & State, or foreign country) 11. during most of working life, even if retired) death certificate 13. FATHER'S NAME he attending phy permit. Then p tion, or removal, MOTHER'S MAJOEN NAME 15/WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unkown) (If yes give war or dates of service) I-transit permil, cramation, c None CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). requires that the à PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) or attending physician. n signed b burial-tran burial, cra DUE TO Cenditions, If any, which peen gave rise to immediate as the b DUE TD cause (a), stating the underlying cause last. has CERTIFICATION PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) for use Health certificate 20a, ACCIDENT WAS UNDERLYING DE CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) PHYSICIAN: 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part | or Part || of Item 18.) r this certifi detached for te Dept. of F MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) be de State I factory, street, office bldg., etc.) Hour a.m. Not While While After ATTENDING at work at work retained TO FUNERAL DIRECTOR: A director, page 3 should should be filed with the the 1906 21. I certify that W (this hospital) attended the deceased from 1966, and that death occurred at 750 M, from the causes and on the date stated above. saw the deceased alive on. 22a. SIGNATURE page STAFF ATTENDING DIRECTOR M.D. PHYS. may O HOSPITAL 22c. PHYSICIAN'S 22d. ADDRESS director, p NAME (Type) 4 BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) BEMOVAL (Specify) Cemeteru ancaste 25a. REC'D BY REGISTRAR 25b. FUNERAL DIRECTOR

VR A15 (4) 20M 1/65

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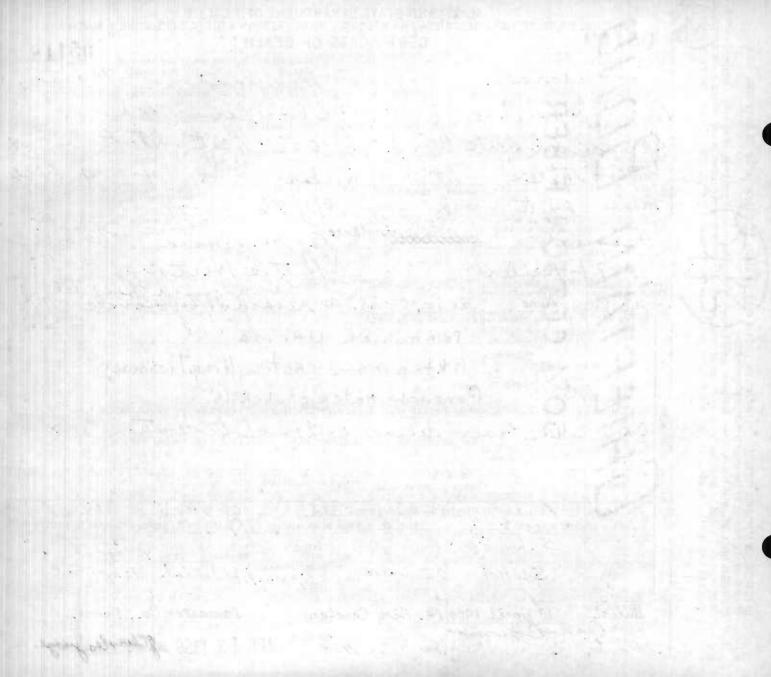
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where decassed lived, If institution: Residence before admission . COUNTY b. COUNTY 15 th death. Carroll MARYLAND Maryland Carroll by the b. CITY OR TOWN (if outside corporate limits. c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) c. LENGTH OF STAY IN 16 24 write RURAL and give nearest town) .5 Middleburg
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give streat address) scuted within New Windsor e. IS RESIDENCE d. STREET ADDRESS ON A FARM? Brookfield Manor Nursing Street YES NO Dabers. Church 3. NAME OF 72 4. DATE Month Year OF DECEASED (Typa or print) DEATH 1966 Florence H. Lindsay carbon 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED IF UNDER 24 HRS. 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR last birthday) Months WIDOWED W DIVORCED remaye 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foraign country) 12. CITIZEN OF WHAT COUNTRY done during most of working life, even if ratirad) any home Maryland U. S. A. Housekeeper please 2 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME attending and Martha Repp Theodore Harman Then removal, 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT (Yas, no, or unkown) | (If yas giva war or datas of service) Westminster, Ma. Lindsay permit. None Russell signed by 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). 5 ONSET AND DEATH PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cremation, burial-transit DUE TO attending peen Conditions, if any, which gave rise to immadiate cause DUE TO (a), stating the underlying the hospital or certificate PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(+) 19. WAS AUTOPSY SE 0 CERTIFICATION PERFORMED? use prior NO TH detached for 20a. ACCIDENT WAS UNDERLYING [2Db. DESCRIBE HOW INJURY OCCURRED. (Entar nature of injury in Part I or Part II of item 18.) After this of Health OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) be retained by WEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED I 20e. PLACE OF INJURY (Home, farm,) 20f. (City or town) (County) (State) factory, street, office bldg., etc.) While Not Whila Hour e.m. DIRECTOR: at work at work p.m. pe 21. 1 certify that (1) (this hospital) attended the deceased from.... pinous State 166 19 and that death occurred at 15 from the causes and on the date stated above. saw the deceased alive on.... 22b. DATE 22e. SIGNATURE ATTENDING SIGNED HOSPITAL FUNERAL page PHYS. DIRECTOR PHYS. M.D. Page with 22c. PHYSICIAN'S 22d. ADDRESS NAME (Typa) ector, filed Robertson 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (Stata) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 中岛 10 0 REMOVAL (Spacify) Md. New Windsor Rural Bethel Cemetery Burial 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) 2DM 5-63

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	he of the sit partitions with the mati	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: ONSET AND DEATH
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	2 0 0 c	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) County County
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34	ATTENDI retained CTOR: A Should vith the S	saw the deceased glive on 4-16-19-6, and that death occurred at 50M, from the causes and on the date stated above
	4 E O Z	22a. SHGNATURE 22a. SHGNATURE M.D. ATTENDING MED. STAFF 22b. DATE SIGNED 4-16-66
	may AL D pag e file	22c. PHYSICIANYS
	TO HOSPITAL OR Page 4 may be O FUNERAL DIRE director, page 3 should be filed v	1 DEED 1111
	Pa To F dir sho	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) Burial 4/19/66 Loudon Park Cemetery Baltimore, Maryland
	N	24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
	VR AIS (4)	Wm. Cook-Brooks Inc. 1217 St. Paul St. DAPR 19 1966 furantes Judge
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05124 CERTIFICATE OF DEATH death. requires that the death certificate be executed within 24 hours after death the attending physician and campletely filled in by the funeral sit permit. Then please remove taxban papers. Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b. COUNTY Balto. City Carroll Maryland MARYLAND c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn) CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 42vrs.5mos.25dys. Baltimore Sykesville d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital (unknown) YES NO X 3 NAME OF Middle 4. DATE Last Manth Day DECEASED event, (Type or print) LENA (MADELINE) APRIL 19 66 MANNING (none) DEATH IF UNDER 1 YEAR | IF UNDER 24 HRS. 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED last birthday) Months Days Female White WIDOWED X DIVORCED 11-11-92 10g. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of warking life, even if retired) INDUSTRY COUNTRY? Maryland
14. MOTHER'S MAIDEN NAME U.S.A. Housewife
13. FATHER'S NAME (Unknown) (Unknown) 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, na, ar unknown) (If yes give war ar dates of service) Records, Springfield State Hospital None No 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), opd (c).) INTERVAL BETWEEN burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) DUE TO Rterioselerosis Conditions, if ony, which gave rise ta immediate cause (a). **DUE TO** stoting the underlying couse the haspital ar attending TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital ar attending TO FUNERAL DIRECTOR: After this certificate has been as the 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) far use YES X NO Schizophrenic reaction, paranoid type. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (County) (State) Not While factory, street, affice bldg., etc.) at work at wark 21. I certify that (I) (this haspital) attended the deceased fram 10-11 1966, that (H) (we) last 19.66, and that death accurred at 12:3M, Fam Louses and an the date stated above saw the deceased alive on 4-6 220. SIGNATURE 22b. DATE SIGNED ATTENDING 4-6-66 Umm M.D. PHYS DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S Ilse Kamm, M.D. Sykesville, Maryland NAME (Type) 230. BURIAL, CREMATION, BENOVAL (Specify) 23d LOCATION (City or Town) (Count) Baltimore, Maryland 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (State) 4-11-1966 Mt. (armel 2So. REC'D BY REGISTRAR ADDRESS 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Milanely VR A15 (4) 20 M 1/66 Lilly & Zeiler Inc. 190107 Eastern Ave. 1966

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 death. hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY b. COUNTY Carroll and completely filled in by the incurrence carbon papers. Pages 1 any event, within 72 hours after MARYLAND Maryland Anne Arundél CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH DF STAY IN 1b Sykesville 3yrs.7mos.17dys Linthicum Heights d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS 202 Homewood Road Springfield State Hospital 3. NAME DE Middle Last DATE Month DECEASED BLANCHE CLARICE MASSEY APRIL (Type or print) DEATH 5. SEX AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. 6. COLOR OR RACE | 8. DATE OF BIRTH 7. MARRIED NEVER MARRIED last birthday) Months | Female White 11-11-02 WIDOWED J DIVDRCED T attending physician a ermit. Then please re 1Da. USUAL OCCUPATION (Give kind of work done) = 1Db. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) death certificate be Waitress/housekeeper Virginia 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Roland Kelly Adeline Shea 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unkown) | (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address as been signed by the atten as the burial-transit permit. prior to burial, cremation, or No Records, Springfield State Hospital (none) 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c),] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). PHYSICIAN: The law requires that to the hospital or attending physician. Coronary occlusion 201 Arteriosclerotic coronary disease Conditions, If any, which gave rise to immediate DUE TD cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Chronic Brain Syndrome associated with presentle brain disease, without qualifying phrase 200a. Accident was underlying phrase 200b. Describe How Injury Occurred. (Enter nature of Injury In Part I or Part II of Item 18.) CIP EITHER, NOTIFY MEDICAL EXAMINER) certificate h hed for use t. of Health p this certi etached f Dept. of 2Dc. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED | 2De. PLACE DF INJURY (Home, farm, 2Df. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. After Id be d Not While OR ATTENDING be retained by at work at work 8-27 1962 to 4-14 1966 that (#) (we) last 21. I certify that (+) (this hospital) attended the deceased from.... DIRECTOR: age 3 should illed with the saw the deceased alive on 4-14 19.66, and that death occurred at 9:50M from the causes and on the date stated above. 22b. DATE SIGNED 22a. SIGNATURE page April 14, 1966 ATTENDING DIRECTOR . PHYS. PHYSICIAN'S 22d. ADDRESS director, p NAME (Type) Ilse Kamm, M.D. Sykesville, Maryland 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) BURIAL, CREMATION, Del. Delmar. 4-16-66 St Stephens 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE FUMERAL DIRECTOR ADDRESS

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INTERVAL BETWEEN ONSET AND DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: Page 4 may be retained by the hospital or TO FUNERAL DIRECTOR: After this certificate	director, page 3 should be detoched for use os the should be filed with the State Dept. of Health prior to	230	BURIAL, CREMATION, 23b. DATE THEREOF,	HARSHEY MD.	REMATORY Bun I	23d. LOCATION (City or Town	(County) (State)
	15 (4) . 1766	24	FUNERAL DIRECTOR	ADDRESS AT LATES	2So. REC'D BY		TRAR'S SIGNATURE
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05127 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 haurs after death death and campletely filled in by the funeral 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH o. COUNTY o. STATE b. COUNTY Carroll Maryland **MARYLAND** ve carbon papers. Pages 1 event, within 72 haurs after c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If autside carparate limits, Rural--Sykesville 6mo. 11days Baltimore d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 2806 Roselawn Avenue Springfield State Hospital NO T t permit. Then please remove carbon pa 3. NAME OF Middle 4. DATE Last Day Year DECEASED 12 19 66 4 Laura Mettee Virginia DEATH (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS. DATE OF BIRTH 9. AGE (In years S. SFX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED birthdoy) Months Days Hours 03/12/80 3.0 white WIDOWED DIVORCED female 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (Caunty & State, ar fareign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY USA Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Mary Elizabeth Main Richard Tydings 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, na, ar unknawn) (If yes give war ar dates af service) Springfield Hospital records-Sykesville 218-46-2460 signed by the atter burial-transit permit burial, crematian, o INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) ONSEL AND DEATH PART I. DEATH WAS CAUSED BY: Bronchopneumonia IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital or attending physician. DUE TO Uremia days Conditions, if any, which gove (b) rise to immediate cause (a), DUE TO for use as the k f Health priar ta b stating the underlying couse **DIRECTOR:** After this certificate has been Arteriosclerotic cardiovascular disease years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)

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BUR TAL April 16.1966 Oaklawn Cemetery Baltimore, Maryland Clientes S BAL DIRECTOR VR A15 (4) 20 M 1/66 LEMHON 4611 Park Heights Ave.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Carrell MARYLAND	USUAL RESIDENCE (Where deceased lived, If institution: Re a. STATE Maryland b. COUNTY 1100	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL Cumberland	and give nearest town)
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital	d. STREET ADDRESS 12 Harrison Street	e. IS RESIDENCE ON A FARM? YES NO A
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5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCED DIVORCED	9. AGE (In years IFUNDER 1 7 pointhday) yrs.	YEAR IF UNDER 24 HRS. Days Hours Min.
1Da. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 1Db. KIND OF BUSINESS OR LYDISTRY	11. BIRTHPLACE (County & State, or foreign country) 12. CI	TIZEN OF WHAT
Ret. Owner & Prop. Antique pasiness 13. FATHER'S NAME Michael Morrissey	14. MOTHER'S MAIDEN NAME Annie Purlong	U.S.A.
(Yes, To on unkown) (If some war or dates of service)	INFORMANT Address Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BY ON Cho pren DUE TO	1 0, 0 0 5	INTERVAL BETWEEN CONSET AND DEATH
(6)	fic Cardio vas cular disease lerro - s derosis. TED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	119. WAS AUTOPSY
Chronic Brain Syndrone of Unknown Cau		PERFORMED?
G OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	RRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 20e. PLAK factor 4 work 20c. PLAK factor 20c. PLAK factor	CE OF INJURY (Home, farm, 20f. (City or town) (Courry, street, office bidg., etc.)	nty) (State)
21. I certify that we thus hospital spinded the decesta hoth	death occurred at, from the causes and on the	TE SIGNED
22c. PHYSICIAN'S R.G. Lajonchere	22d. Abgress Springfield State Hos	pital
23a. BURIAL, CREMATION, REMOVAL (Specify) 5/3/66 23c. NAME OF CEMETERY SS. Peter & P.	Paul Cem. Cumberland Mary	land
24. FUNERAL DIRECTOR ADDRESS H. Wayne George Cumberland, Maryland	DMAY 3 1966 Icharles	

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MARYLAND STATE DEPARTMENT OF HEALTH

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CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If institution, Residence before edmission, a. COUNTY b. COUNTY Carroll Carrol] Maryland MARYLAND b. CITY OR TOWN (if outside corporete limits c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporete limits, write RURAL end give nearest town) write RURAL and give nearest lown) Rural Tanevtown Rural Middleburg 4 Weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS IS RESIDENCE ON A FARM? YES Y NO Brookfield Manor Nursing Home 3. NAME OF Middle 4. DATE DECEASED OF (Type or print) DEATH April 1966 Grace Motter 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX 8. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. and last birthday) Months Deys Hours WIDOWED 3 Sept. 4, Female 10a. USUAL OCCUPATION (Give kind of work physician 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & Stele, or foreign country) 12. CITIZEN OF WHAT COUNTRY? one during most of working life, even if retired) U.S.A. Housewife Own home Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Thomas Baker Elizabeth Shriner 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) | (If yes give wer or detes of service) Mr. Clarence J. Motter, Taneytown. 18. CAUSE OF DEATH [Enter only one ceuse per line for (e), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: 2 days IMMEDIATE CAUSE (e) Combral atherosoleroses and throm bosts DUE TO Conditions, if eny, which (b) gove rise to immediate cause DUE TO (e), steting the underlying cause last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(*) 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO 20e. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Pert I or Part II of item 18.) OR CONTRIBUTING IT CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, ferm, 20f. (City or town) (County) (Stete) factory, street, office bldg., etc.) White Not While Hour e.m. at work et work D.m 0 ..., 19....., that (I) (we) last19......, and that death occurred at 1/32 M, from the causes and on the date stated above. saw the deceased alive on... 22at SIGNATURE 22b. DATE ATTENDING SIGNED DIRECTOR PHYS. PHYS. 22d. ADDRESS 22c. PHYSICIAN NAME (Mpe) Union Bridge, Maryland .H. Caricofe 23a, BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) の音る 5. 1966 Mt. View Cemetery Emmitsburg, Maryland 250. REC'D BY REGISTRAR 256. REGISTRAR 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS VR A15 (4 C.O.Fuss & Son, TaneytownmMd 15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05131 CERTIFICATE OF DEATH funerol s 1 and 2 ter death 24 hours after deoth PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY b. COUNTY Maryland Carroll papers. Pages 1 hin 72 hours after MARYLAND c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, Rural -- Sykesville 10y. 11m. 6d. Baltimore filled in d. STREET ADDRESS IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 311 Cathedral Street Springfield State Hospital YES NO certificate be executed within 3. NAME OF First Middle Lost 4. DATE Month completely f Don ÷. Doy Year DECEASED OF 19 66 Margaret Dolores Murray 4 24 event, (Type or print) DEATH IF UNDER 24 HRS. SEX DATE OF BIRTH IF UNDER 1 YEAR 6. COLOR OR RACE AGE (In years 7. MARRIED NEVER MARRIED rerprove birthdoy) Hours 6/15/82 female white dux WIDOWED DIVORCED and 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done and in during most of working life, even if retired)
Registered nurse COUNTRY? ottending physician overmit. Then please INDUSTRY USA Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, cremation, or removal, Daniel A. L. Murray Anna Cecilia Ward 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT requires that the death 16. SOCIAL SECURITY NO Address (Yes, no, or unknown) (If yes give wor or dotes of service) Springfield Hospital records -- Sykesville unknown INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the burial-transit MSTAW DEATH PART 1. DEATH WAS CAUSED BY: Cardiac failure IMMEDIATE CAUSE (o) DUE TO Carcinoma breast metastasis years Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse Page 4 may be retained by the hospital or ottending FUNERAL DIRECTOR: After this certificate has been irector, page 3 should be detached for use as the hould be filed with the State Dept. of Health prior to PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0).

Chronic brain syndrome associated with cirquilatory disturbance, 19. WAS AUTOPSY PERFORMED? YES NO with cerebral arteriosclerosis with psychotic reaction. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. foctory, street, office bldg., etc.) Not While ot work ot work 21. I certify that (* (this haspital), attended the deceased fram 5/18/ 19 55 top m4/24/ . 19 66 that A (we) last director, page 3 should should be filed with the 19 66 and that death accurred at 1:45 M. fram causes and on the date stated above. saw the deceased alive an 22b. DATE SIGNED 220. SIGNATURE ATTENDING 4/24/66 M.D. PHYS PHYS Springfield State Hospital 22d. ADDRESS 22c. PHYSICIAN'S Naci Buyukunsal, NAME (Type) Sykesville, Maryland 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 230. BURIAL, CREMATION DATE THEREOF (County) (Stote) REMOVAL (Specify) MORP 0 250. REC'D BY REGISTRAR APR 29 2Sb. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66

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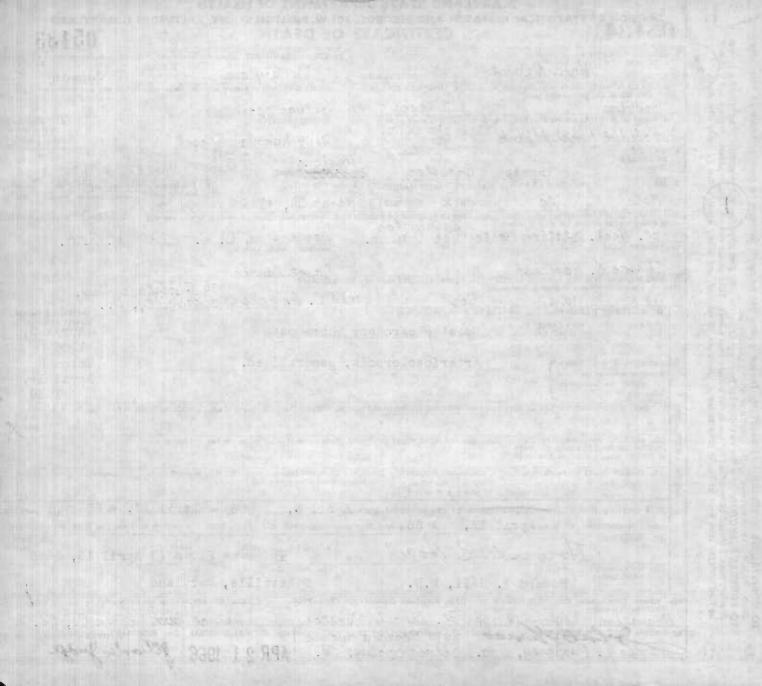
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 death: hours after death, PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY a. STATE b. COUNTY Carroll by the f Pages 1 irs after MARYLAND Maryland Montgomery CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b 11 m Rural) Sykesville = Hagerstown 21740 papers. in 72 hc d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE filled d. STREET ADDRESS Springfield State Hospital ON A FARM? NO . Wilson BoulevaraYES W within 3. NAME OF DATE Month First Elmer Last DECEASED 1966 event. comple ve cart LMIRE (Type or print) DEATH Ver5 TOA 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS remove Sast birthday) Months | Days 10-3-1881 any and MIDOMEO DIVORCEO [male white = 10a. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) ease death certificate be during most of working life, even if retired) INDUSTRY earross COUNTRY? ash and USA physic Farmer Maryland MOTHER'S MAIDEN NAME 0 removal. 13. FATHER'S NAME attending ph William Myers Mary A. Sprankle 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address ed by the attenctransit permit. (Yes, no, or unkown) (If yes give war or dates of service) 217-12-1840 Hospital Records none 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN that the ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY: Bronchopneumonia IMMEDIATE CAUSE (a) signed DUE TO Conditions, If any, which been gave rise to Immediate the DUE TO cause (a), stating the underlying cause last. has as 19. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) for use Health PERFORMEO? certificate Chronic brain syndrome associated with cerebral arteriosclerosis NO K 71th psychotic reaction
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OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) PHYSICIAN: this cerum detached for 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm,) (County) (State) 20c. TIME OF INJURY Month, Oay, Year factory, street, office bldg., etc.) While at work at work After Id be d p.m. retained 3 should with the 5-20-4-28 1966_, that (we) last 21. I certify that (1) (this hospital) attended the deceased from_ DIRECTOR: and that death occurred at 245PM. from the causes and on the date stated above. saw the deceased alive on 22b. DATE SIGNED 22a. SIGNATURE page STAFF M.D. PHYS. DIRECTOR director, pa PHYSICIAN'S 22c. 22d. AODRESS NAME (Type) Sam P. Wise III Springfield State Hospital BURIAL, CREMATION, 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) dfording 25MATEC'D BY REGISTRAR 24. FUNERAL DIRECTOR ADDRESS erstown VR A15 (4) OATE

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05433 05132 CERTIFICATE OF DEATH requires that the deoth certificate be executed within 24 hours after death pup 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH attending physicion ond completely filled in by the funeral permit. Then please remove corbon papers. Pages I and a. COUNTY o. STATE b. COUNTY MARYLAND c. LENGTH OF STAY IN 1b) b. CITY OR TOWN (If autside carparate limits. c. CITY OR TOWN (If outside corparate limits, write RURAL and give negrest tawn) write RURAL and give negrest town) e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS within , NO 3. NAME OF First Middle Last DATE Manth Day Year DECEASED 19 66 DEATH (Type ar print) IF UNDER 1 YEAR S. SEX AGE (In years last birthday) IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED DATE OF BIRTH Months Doys Hours DIVORCED WIDOWED 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS ØR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY ? 13. FATHER'S NAME luce MOTHER'S MAIDEN NAME IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) ((If yes give war or dotes of service) cremotion, 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) INTERVAL BETWE buriol-tronsit PART I. DEATH WAS CAUSED BY: APHEAGMATIC IMMEDIATE CAUSE (a) þ DUF TO buriol, CTERIOSCLEROTIC Conditions, if ony, which gove rise ta immediate cause (a), DUF TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been os the last. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? use BBETES ELLITUS NO YES the hospitol or for 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH jo detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) foctory, street, office bldg., etc.) Not While at work ro Hospital or Attenbin Page 4 may be retained by , 1966, ta 4/28, 1966, that (1) (we) last 21. I certify that (1) (this haspital) attended the deceased fram and that death accurred at 433M, from causes and on the date stated above. 4/28 1966 saw the deceased alive an 220. SIGNATURE 22b. DATE SIGNED ATTENDING MED. DIRECTOR Luceux M.D. PHYS. PHYS 22d. ADDRESS 22 PHYSICIAN'S NAME (Type) director, 23b. DATE THEREOF NAME OF CEMETERY OR GREMATORY 23d. LOCATION (City or Town) (County) 23a. BURIAL, CREMATION, (Stote) REMOVAL (Specify) 24. FUNERAL-DIRECTOR 25g. REC'D BY REGISTRAR ADDRESS VR A15 (4) 20 M 1/66 Charles

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05135 Hemis 05134 CERTIFICATE OF DEATH 24 haurs ofter death ond deoth 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if iristitution: Residence before admission) and completely filled in by the funeral remove carbon popers. Pages 1 and o. COUNTY Carroll o. STATE Maryland Baltimore City MARYLAND within 72 hours after c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If outside corporate limits. write RURAL and give nearest town)
Sykesville Baltimore 25 dvs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? No fixed address Springfield State Hospital YES NO X within PH F F Cast 3. NAME OF Middle 4. DATE Month Dov Year DECEASED SHERMAN HENRY PHEFFER. APRIL 16 66 19 (Type or print) DEATH prior ta buriol, crematian, or removal, and in any everat, requires that the death certificate be executed AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. SEX 8. DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Jost birthdoy) Months Doys Hours Male Negro Sep . DIVORCED 7-5-11 WIDOWED 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) physicion a during most of working life, even if refired)

Laborer INDUSTRY U.S.A. Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Unk. Anna Harris 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service) 218-05-5888 Records, Springfield State Hospital Yes Unk. 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) INTERVAL BETWEEN signed by the burial-tronsit p Days PART I. DEATH WAS CAUSED BY: IMMEDIATE (AUSE (o) Bilateral bronchopneumonia Page 4 moy be retained by the hospitol or ottending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stating the underlying couse as the 19. WAS AUTD PSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) director, page 3 should be detached for use should be filed with the Stote Dept. of Heolth NO K O FUNERAL DIRECTOR: After this certificate 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME DF INJURY Month, Doy, Yeor foctory, street, office bldg., etc.) Not While ot work ot work 19:15 to 11-16-66, 19_, that (I) (we) last 21. I certify that (1) (this haspital) attended the deceased fram 3-21-66 sow the deceased alive an 4-16-66 and that death occurred at M. from causes and an the date stated above. 22b. DATE SIGNED 22o. SIGNATURE MED. DIRECTOR **ATTENDING** 4-19-66 M.D. 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S NAME (Type) Sykesville, Maryland Octavio A. Ruiz. M.D 23d. LOCATION (City or Town) NAME OF CEMETERY DR CREMATORY 23a. BURIAL CREMATION 23b. DATE THEREDF (Stote) REMDVAU (Specify) 250. REC'D BY REGISTRAR VR A15 (4)

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 hours after death, and PLACE DF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) Pages 1 b. COUNTY Carroll Maryland Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENCTH OF STAY IN 1b (Rural) Sykesville 9yr. 11mo. 4da. Silver Spring = d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE d. STREET AOORESS ON A FARM? Springfield State Hospital Silver Spring Ave. YES NO TO 3. NAME OF Middle Last 4. DATE Month DECEASED car (Type or print) Herbert William DEATH 19 66 Priestley 6. COLOR OR RACE | 7. MARRIEO AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 8. OATE OF BIRTH remove NEVER MARRIED last birthday) | Months | Days in any and WIDOWED [DIVORCED male white 9-8-85 80 yrs. 10a. USUAL OCCUPATION (Cive kind of work done | 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT death certificate be during most of working life, even if retired) INDUSTRY COUNTRY? Carpenter Maryland

14. MOTHER'S MAIDEN NAME TISA removal, 13. FATHER'S NAME attending ph William Priestley Elizabeth Penophyl 15. WAS DECEASED EVER IN U.S. ARMED FORCES? ed by the attend transit permit. cremation, or r 16. SOCIAL SECURITY NO. | 17. INFORMANT (Yes, no, or unkown) (If yes give war or dates of service) unknown 579-07-1409 Hospital Records INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] ed by the ONSET AND DEATH PART I. OEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Arteriosclerotic heart disease vears been signed the burial-tra DUE TO Generalized arteriosclerosis years Cenditions, If any, which (b) gave rise to immediate DUE TD cause (a), stating the as th underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? for use Health certificate Chronic brain syndrome, associated with psychotic reaction YES T NO T this certetached for 20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING DC CAUSE DF OEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) PHYSICIAN: 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) at work at work factory, street, office bldg., etc.) Hour a.m. 1956 to_ . 19.66, that \$\(\text{th}\) (we) last 0 21. I certify that ? (this hospital) attended the deceased from. 4-25 shoul DIRECTOR: 19 66, and that death occurred at 5-45M, from the causes and on the date stated above. saw the deceased alive on 3 sho 22b. DATE SICNED 22a. SIGNATURE a.m. 4-25-66 page ATTENDING PHYS. MED. acc DIRECTOR **PHYSICIAN'S** 22d. AOORESS TO FUNERAL 22c. director, p should be 1 NAME (Type) Springfield State Hospital BURIAL, CREMATION. 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (Stale) REMOVAL (Specify) UNERAL DIRECTOR ADDRESS 25a. KEC'D BY REGISTRAR 25b. REGISTRAR'S SICNATURE 1966 VR A15 (4) 20M 1/65

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05137 CERTIFICATE OF DEATH death. requires that the death certificate be executed within 24 hours after death by the funeral Pages 1 and 2 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY b. COUNTY Maryland Carroll Howard and completely filled in by the fur remave carban papers. Pages 1 in any event, within 72 hours after MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) Rural Sykesville 2mo. 7days Laurel d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital Route #1 YES NO 3. NAME OF First Middle Last 4. DATE Month Doy Year DECEASED OF 25 66 Ranlett Glades Ethel 19 (Type or print) DEATH S. SEX B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 7 last birthdoy) Doys Hours white 8/15/90 female DIVORCED WIDOWED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT signed by the attending physician ar burial-transit permit. Then please p burial, crematian, ar remaval, and in during most of working life, even if retired) INDUSTRY COUNTRY? USA Washington D.C. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Daniel Sullivan unknown 1S. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dates of service) 17 INFORMANT 16. SOCIAL SECURITY NO. Springfield Hospital records-Sykesville 578-09-1290 no 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH Acute myocardial infarction IMMEDIATE CAUSE (o) Page 4 moy be retained by the hospital ar attending physician. DUF TO Conditions, if ony, which gove Occlusion of left coronary artery due to rise to immediate couse (a), DUE TO stoting the underlying couse thrombosis min. **TO FUNERAL DIRECTOR:** After this certificate has been directar, page 3 shauld be detached far use as the shauld be filed with the State Dept. af Health priar ta PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o).

Chronic brain syndrome associated with cerebral arteriosclerosis 19. WAS AUTOPSY PERFORMED? YES 🚍 with psychotic reaction. NO 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) 20e. PLACE OF INJURY (Home, form, (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED foctory, street, office bldg., etc.) Not While 1966 , te m 4/25/, 19 66 that (F (we) last 21. I certify that A (this haspital) attended the deceased from 4/25/ 1966, and that death accurred at 12:35%, fram causes and an the date stated obove. saw the deceased alive an_ 22b. DATE SIGNED 22o. SIGNATURE STAFF PHYS. ATTENDING X 4/25/66 DIRECTOR M.D. PHYS Springfield State Hospital 22d. ADDRESS 22c. PHYSICIAN'S Edmee J. Reeves, M. D. NAME (Type) Sykesville, Maryland 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify)
Burial Arlington, Virginia Arlington National 20 ADDRESS Washington, 2Sb. REGISTRAR'S SIGNATURE The STRECTOR 2So. REC'D BY REGISTRAR Company VR A15 (4) 20 M 1/66 1966

MARYLAND STATE DEPARTMENT OF HEALTH

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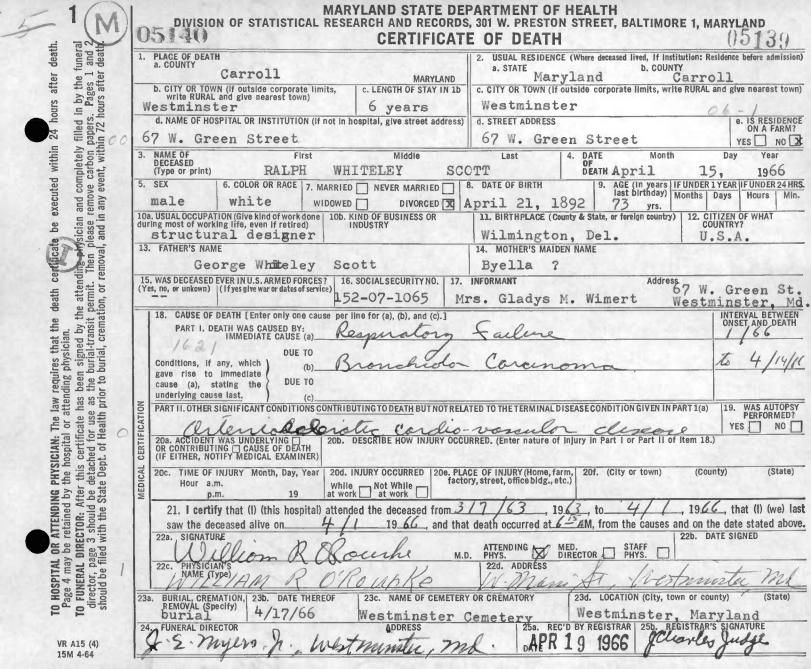
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral 1 and 2 r death after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, 1f institution: Residence before admission) a. COUNTY b. COUNTY Pages 1 urs after Carroll Carroll Marvland MARYLAND b. CITY DR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENCTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) à on papers. Pag within 72 hours 24 hours Westminster = Westminster 1 Month Rt. Rural d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8. IS RESIDENCE ON A FARM? d. STREET ADDRESS completely filled Cranberry Road Rt. #L Snydersburg Road YES ND ND executed within carbon 3. NAME OF First Middle DATE Last Month Year Day DECFASED DF DEATH Thomas (Type or print) Rayner April 1966 Dewey 6. COLOR DR RACE | 7. MARRIED X NEVER MARRIED SEX DATE OF BIRTH ACE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS remove last birthday) Days Months Hours Caucasian Male April 1. 1898 WIDOWED [DIVORCED | physician a = 10a. USUAL OCCUPATION (Cive kind of work done | 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT COUNTRY? 11. BIRTHPLACE (County & State, or foreign country) **O HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be Page 4 may be retained by the hospital or attending physician. during most of working life, even if retired) INDUSTRY Coal Miner Coal Mines Frostburg, Maryland U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME attending permit. Then Thomas D. Rayner Mary Carr 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SDCIAL SECURITY ND. 17. INFORMANT Address R-1 50 (Yes, no, or unkown) (If yes give war or dates of service) Christina Lentic-Brodbecks, Pa. burial-transit pern burial, cremation, No 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH this certificate has been signed by PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which (b) gave rise to Immediate as the prior to DUF TD cause (a), stating the underlying cause last. (c) CERTIFICATION PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART 1(a) WAS AUTDPSY detached for use e Dept. of Health PERFORMED? NO Z YES 20a. ACCIDENT WAS UNDERLYINC ☐ DR CONTRIBUTING ☐ CAUSE DF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. After Not While While at work Stat at work p.m. TO FUNERAL DIRECTOR: A director, page 3 should should be filed with the 0 the that (I) (we) last 21. I certify that (!) (this hospital) attended the deceased from_ saw the deceased alive on. 19 / (e. and that death occurred at 6 _M. from the causes and on the date stated above. 22a. SIGNATURE 22b. DATE SICNED ATTENDING DIRECTOR M.D. PHYS. PHYS. PHYSTCIAN'S 22d. ADDRESS 22c. NAME (Type) Donald Knight, A. BURIAL, CREMATION, REMDVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) Finksburg Maryland Burial Evergreen Memorial Gardens 24. FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SICNATURE 1966 Hampstead, Md. 21074 VR A.15 (4)

MARYLAND STATE DEPARTMENT OF HEALTH

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1.	PLACE OF DEATH			2. USUAL RESIDENCE (W	here deceased lived. If institut		efore admission)
	Carr	coll	MARYLAND	Marylan	d Ca	rroll	
	b. CITY OR TOWN (I RURAL and give no	f outside corporate limits, write	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (IF	outside corporate limits, write l	RURAL and give r	nearest town)
	Westmir			Westmin	ster	06	1 3
	d. NAME OF HOSPIT	'AL (If not in hospital, give stree	t address)	d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?
				6 Wimer	t Avenue		YES NO D
3.	NAME OF DECEASED	First	Middle	Last	4. DATE Mor	nth	Day Year
	(Type or print)	George	Emerson	Rue	DEATH apr	, (5 1966.
S.	SEX	6. COLOR OR RACE . MAI	RRIED T NEVER MARRIED	B. DATE OF BIRTH	9. AGE (In years lost birthdoy)		AR IF UNDER 24 HRS.
	Male	White WIDOV		March 23, 19	03 63 yrs.		s Hours Min.
100	during most of work	ON (Give kind of work done 10b	. KIND OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (Stote	or foreign country)	12. CITIZEN	OF WHAT COUNTRY?
)	Machinery		oad building	Cambridge.	Maryland	U.S.	Α.
13.	FATHER'S NAME			14. MOTHER'S MAIDEN			
	Tilden	W. Rue		Mary Ett	a Wroten		
15. (Ye	WAS DECEASED EVE	R IN U. S. ARMED FORCES? 16	SOCIAL SECURITY NO.	INFORMANT		dress	
	No		18-09-0521 M	rs. Marion Ru	e. Tanevtown.	Maryland	1
	1B. CAUSE OF DEA	TH [Enter only one couse per				11	NTERVAL BETWEEN NSET AND DEATH
	PART I. DEA	TH WAS CAUSED BY: IMMEDIATE CAUSE (6)	ronchiecto	sis		0	NSET AND DEATH
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	Conditions, if or	ny, which) (b)	nonie am	physeme	(,		
	gove rise to it couse (o), stoting	mmediote Dus TO	1				
	lying couse lost.	(c)	nonic Mal	nutution	-		
O	PART II. OTH	IER SIGNIFICANT CONDITIONS	CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERM	INAL DISEASE CONDITION GE	VEN IN PART 1(o	19. WAS AUTOPSY PERFORMED?
CAT	Carrier States						YES NO D
CERTIFICATION	20a. ACCIDENT WA	S UNDERLYING 1 20b. DE	SCRIBE HOW INJURY OCCURRE	D. (Enter noture of injury in	Port I or Port II of item 1B.)		
	(IF EITHER, NOTIFY	CAUSE OF DEATH MEDICAL EXAMINER)					
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MED	Hour o.m.	19 While	Not while fork of work	ciory, sireer, office blog., en			
	21. I certify th	at I attended the decea	sed from 4/5	19 66 ta	11/5/10/	that I last s	aw the deceased
	24	lever 19		- 45	AM, fram the causes ar		
		· • • • • • • • • • • • • • • • • • • •	10		ADDRESS (Street, city or town,		DATE SIGNED
	ACTUAL SIGNATURE	11001pm K	Dogoula	40 150	W. Main	7	4-5-66
	SIGNATURE V	Acces in 1	2.0	.m.u.	- 4 - 1	L	
	PHYSICIAN'S NAME (Type)	Villiam K	OKourka	Westm	inster Md.		
220	BURIAL, CREMATIO	N, 22b. DATE THEREOF	22c. NAME OF CEMETERY C	OR CREMATORY	22d. LOCATION (City, town,	or county)	(Stote)
	REMOVAL (Specify)	Apr. 7. 1966				arvland	Whole Is
23,	FUNERAL DIRECTOR		ADDRESS	24a. REC	D BY REGISTRAR 246. REG	ISTRAR'S SIGNAT	TURE
Sp	An H. Si	Ciles C.O. Fuss	& Son, Taneyton	wn.Md. DATE	K7 1966 /	carles	Judge.
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH death. funeral 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY a. STATE b. COUNTY after after the Carroll Baltimore City MARYLAND Marvland by the Pages b. CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (If outside corporete limits, write RURAL end give nearest town) c. LENGTH OF STAY IN 1b papers. The papers ? write RURAL and give nearest town) hours Baltimore 12vrs.2mos.26dvs. 2 Sykesville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street eddress) filled d. STREET ADDRESS e. IS RESIDENCE ON A FARM? within Springfield State Hospital 804 Wellington Ave. YES NO CC executed within completely carbon 4. DATE Middle Month Day Year DECEASED ODEN SHERIDAN SHIPLEY APRIL 19 66 (Type or print) DEATH event 6. COLOR OR RACE | 7. MARRIED DC NEVER MARRIED 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. emove last birthday) | Months | Days Hours and any Male White WIDOWED 3-11-13 DIVORCED 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INDUSTRY .= 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) physician pe COUNTRY? and Mechanic at Beth. Steel Co. Maryland U.S.A. certificate removal, 13. FATHER'S NAME MOTHER'S MAIDEN NAME attending primit. Then Thomas L. Shipley Fannie Shoemaker 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT transit permit. 16. SOCIAL SECURITY NO. | Address death (Yes, no, or unkown) (If yes give war or dates of service) Records. Springfield State Howital the 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN been signed by the the burial-transit or to burial, cremati ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Bilateral bronchopneumonia the hospital or attending physician. Days IMMEDIATE CAUSE (a) Conditions, If any, which Possible infected emboli from right ventricle Davs gave rise to immediate wall DUE TO cause (a), stating the as th this certificate has be detached for use as the Dept. of Health prior underlying cause last. CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? CBS assoc. with convulsive disorder, without qualifying phrase YES TO NO T 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Pert I or Pert II of Item 18.) MEDICAL 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (State) 20c. TIME OF INJURY Month, Day, Year (County) Hour a.m. While FUNERAL DIRECTOR: After lirector, page 3 should be dhould be filed with the State Not While be retained by at work at work ATTENDIN 21. I certify that (I) (this hospital) attended the deceased from to4-4-66 __ that (I) (we) last 4-4-66 M. from the causes and on the date stated above. saw the deceased alive on _19_ and that death occurred at 22a. SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. STAFF PHYS. Page 4 may t DIRECTOR PHYSICIAN'S NAME (Type) M.D. 22d. ADDRESS Springfield State Hospital director, p Frances Reid Nabors, M. Sykesville, Maryland 23d. LOCATION (City, town or county) 23c. NAME OF CEMETERY OR CREMATORY (State) BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) 01 Carrollton, Md. Church of God Ce.. 7/66 REC'D BY REGISTRAR 25b, REGISTRAR'S SIGNATURE FUNERAL DIRECTOR ADDRESS 6009 Harford Rd lianles Altenburg -VR A15 (4) Funeral Home, Inc. 15M 4-64

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where daceased lived, If Institution, Residence before admission) a. COUNTY b. COUNTY 幸 7 年 MARYLAND 0 b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 OR TOWN (If outside corporata limits, write RURAL and give an write RURAL and give nearest town) d. NAME OF HOSPITAL d. STREET ADDRESS a. IS RESIDENCE OR INSTITUTION (if not in hospital, give straet address) ON A FARM? YES NO Z pletely 3. NAME OF Middle 4. DATE Month Day Year DECEASED OF (Type or print) DEATH 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. 5. SEX 7. MARRIED NEVER MARRIED last birthday) Months Hours WIDOWED certificate USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) 13. FATHER'S NAM MOTHER'S MAIDEN NAME death FORCES? (If yes give war or dates of service) 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which (b) gave rise to immediate cause DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6)| 19. WAS AUTOPSY CERTIFICATION \$ 0 PERFORMED? NO 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1B.) 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d. INJURY OCCURRED 2De, PLACE OF INJURY (Home, farm, (State) 20c. TIME OF INJURY 20f. (City or town) (County) Month, Day, Year tactory, street, office bldg., etc.) While Not While Hour a.m. at work at work p.m. 0 21. | certify that (1) (this hospital) attended the deceased from ... P M, from the causes and on the date stated above. W. o and that death occured 22a. ATTENDING DIRECTOR PHYS. PHYS. leath. Page 4 22d. ADDRESS 23d. LOCATION (State) CREMATION, 23b. DATE 0:53 REO'D BY REGISTRAR 256. REGIS VR A15 (4) 1SM 7/61

WESTPHALLER OFFICE WEETHINGS HOWARD IKVING SIES - APRIL 19 LE 138881 W YOM 3 THE BITTER BURN BURN ELECTRICIAN BUILDING CARROLL MARVIND C ENT. HOWARD PETER SIES LAURH KATE BURGOWN 1880-21-77 EARCINO MA OF LOWER 2 MIN 199 1187A 20 1189 A 20 1189 A Camel Ittellier WESTER RESIDEE ROOM 4-17

RYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH funeral hours after PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before edmission a. COUNTY b. COUNTY by the and 2 death arro MARYLAND b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL end give neerest town) within 24 write RURAL end give neerest town) after filled in I d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address) d. STREET ADDRESS hours IS RESIDENCE ON A FARM? completely YES NO X papers. 72 3. NAME OF Middle DATE Month Dey Yeer DECEASED carbon pa OF (Type or print) DEATH 1966 5. SEX B. DATE OF BIRTH IF UNDER 24 HRS pue 7. MARRIED X NEVER MARRIED AGE (In years HF UNDER 1 YEAR death certificate be remove car lest birthday) WIDOWED DIVORCED physician 10a, USUAL OCCUPATION (Give kind of work 1Db. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY or foreign country) done during most of working life, aven if retired) arm please 2 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME aftending and Simmons Alice Spencer John Then requires that the oval, 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) | (If yes give we ror detes of service) physician. 18. CAUSE OF DEATH [Enter only one ceuse per line for (e), (b), end (c). INTERVAL BETWEEN 6 ONSEL AND DEATH PART I, DEATH WAS CAUSED BY: been signed IMMEDIATE CAUSE (e) cremation, burial-fransit affending DUE TO Conditions, if eny, which (b) gave rise to immediata cause DUE TO (a), steting tha underlying the ceuse last. the hospital or certificate use as PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY 0 CERTIFICATION PERFORMED? prior NO for 200. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) After this Health OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) defached be retained by 2Dd. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 2Dc. TIME OF INJURY Month, Day, Yeer (Stete) 2Df. (City or town) (County) State Dept. of fectory, street, office bldg., etc.) While Not While Hour a.m. DIRECTOR: et work at work 19 p.m. Pe 21. I certify that (I) (this hospital), attended the deceased from ... 19 that (I) (we) last should ...1966 .A.M. from the causes and on the date stated above saw the deceased alive ..., and that death occurred and may 22b. DATE 22e. SIGNATURE ATTENDING SIGNED HOSPITAL death. Page 4 O FUNERAL page with fl PHYS. DIRECTOR PHYS. M.D. 22d. ADDRESS 22c. PHYSICIAN'S Hampstead, Md. rector, NAME (Type) M 23a. BURIAL, CREMATION, | 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (Stete) Dig 7 Hampstead Cemetery Hampstead Md. 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE ADDRESS 24 FUNERAL DIRECTOR'S SIGNATURE 1966 VR A1S (4) Funeral Home Hampstead 20M S-63

Salan MAY 2 1966

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

	15144		CERTIFICA	TE OF DEATI	H	05143			
	1. PLACE OF DEAT a. CDUNTY Carro		MARYLAND	2. USUAL RESIDEN a. STATE Marylan	b. COUNT	tution: Residence before admission) Y timore Gity			
	Sykesvi		nits, c. LENGTH DF STAY IN 1	b c. CITY DR TOWN (I	f outside corporate limits, write	e RURAL and give nearest town)			
2 =	Springf	SPITAL OR INSTITUTION (IF	not in hospital, give street addres	di ala	8601 Gray Fox	Rd. e. IS RESIDENCE ON A FARM?			
	3. NAME DF DECEASED (Type or print) 5. SEX	First ISADO		Last SINSKEY	4. DATE Month OF OEATH APRIL	Day Year 6 1966			
1	Male		IDDWED DIVDRCED	8. DATE OF BIRTH 2-15-1890		FUNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.			
	Selbement 13. FATHER'S NAM	Hereteroes Mutu	al Dept. Race Tra		, Baltimore	CDUNTRY?			
	Albert	Sinskey EVER IN U.S. ARMEO FORCE	S? 16. SDCIAL SECURITYNO. 1:		t name unk.)				
=	(Yes, no, or unkown)	(If yes give war or dates of serv	ice)		ngfield State Ho				
		EATH WAS CAUSED BY: IMMEDIATE CAUSE (a)_	Uremia			ONSET AND DEATH Months			
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	cause (a), s underlying cau	se last.) (c)_	Generalized arte	ELATED TO THE TERMINAL	DISEASE CONDITION GIVEN IN PA	Years ART1(a) 19. WAS AUTDPSY			
	2Da. ACCIOENT	WAS IINOFRLYING	ile brain disease			PERFORMEO? YES NO Item 18.)			
- 1		ING CAUSE OF CEATH OTIFY MEDICAL EXAMINER) INJURY Month, Day, Year	2Dd. INJURY DCCURRED 20e. F	PLACE DF INJURY (Home, f	arm, 20f. (City or town)	(County) (State)			
1		.m. 19	at work at work	ctory, street, office bldg.,		_, 19, that (I) (we) last			
	saw the de	21. I certify that (I) (this hospital) attended the deceased from 5-20-65, 19 to 1-6-66, 19 that (I) (we) last saw the deceased alive on 4-6-66, 19, and that death occurred at M, from the causes and on the date stated above. 22a. SIGNATURE							
	22c. PHYSICI, NAME (T	Frances Rend alrow M.D. ATTENDING MED. STAFF X 4-6-66							
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral PLACE DF DEATH a. COUNTY USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) the n Pages 1 a. STATE b. COUNTY after CARROLL MARYLAND BALTIMOLE MARYLAND CITY b. CITY DR TDWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) bon papers. Page within 72 hours a hours BALT IMORE filled in d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1485 - 10 mos-11 45. 20-4 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 906W. 37 STREE Has P. +AL YES STATE ND completely 1 NAME OF 3. Middle DATE Month Oav Year DECEASED event, NMN (Type or print) DEATH APRIL 17 19 66 executed 5. SEX 6. COLOR OR RACE 8. OATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS етоме 7. MARRIEO NEVER MARRIEO last birthday) | Months | Days Hours 1 any 1892 FEMMLE WIDDWED DIVORCED 73 = 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY and COUNTRY? HOUSEW, FE MARYLAND L1. 5.4 certificate o u 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME removal attending primit. Then F. MCKEE WILLIAM HMELIA 15. WAS DECEASED EVER IN U.S. ARMED PORCES:
(Yes, no, or unknown) (If yes give war or dates of service) 15. WAS DECEASED EVER IN U.S. ARMED FORCES? ed by the attend transit permit. 16. SOCIAL SECURITY NO. 17. INFORMANT Address death HOSP, TAL RECORDS, SPRINGFIELD STATE 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND OEATH PART I. OEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) signed by attending physician. the hospital or arrows the hospital or arrows the burial-tr DUE TO lized Aiteriosclerosis Conditions, If any, which gave rise to immediate DUE TD cause (a), stating underlying cause last (c) NO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 119. WAS AUTOPSY CHRONIC BRAW SYNDROME WITH CEREBARL ARTERICSCLEROSIS WITH PERFORMED? CERTIFICATI the hospital or YES NO TU BCTION. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) I be detached for State Dept. of H 2Da. ACCIDENT WAS UNDERLYING [DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 120e, PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. After While Not While at work at work be retained should 4-17-66, 19 21. I certify that (1) (this hospital) attended the deceased from 6-8-63 the . to_ Page 4 may be retaine TO FUNERAL DIRECTOR: -66 19 and that death occurred at 3:60. M. from the causes and on the date stated above. saw the deceased alive on 4 - 17 22a. SIGNATURE 22b. DATE SIGNED page M.D. PHYS. DIRECTOR PHYS. PHYSICIAN'S 22d. ADDRESS SPRINGFIELD STATE director, p NAME (Type) SY KES YILLE, MARYLAND BURIAL, CREMATION, DATE THERED NAME OF CEMETERY DR CREMATDRY 23d. LOCATION (City, town or county) (State) PARK WOOD REMOVAL (Specify) BALTO, MO. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE VR A15 (4) 15M 4-64

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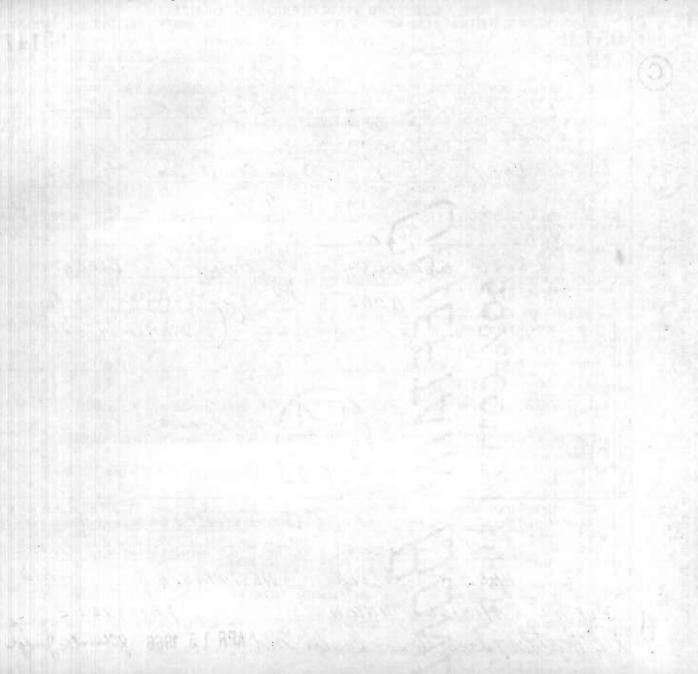
	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
death.	05146 CERTIFICATE OF DEATH 05145
	1. PLACE OF DEATH a. CDUNTY Carroll MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission a. STATE b. COUNTY Carroll MARYLAND
	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville Voodbine
-	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO
=	3. NAME OF First Middle Last 4. DATE Month Day Year DECEASED (Type or print) JOHN JACOB SNYDER DEATH April 20 19 6
-	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 HR Iast birthday) Months Days Hours Min.
-	Male White WIDOWED Septivorced 4-12-74 92 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND DF BUSINESS DR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?
-	Carpenter Maryland U.S.A. 13. FATHER'S NAME Linknown Language Linknown Unknown Linknown Lin
-	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 17. INFORMANT Address 214-16-0951-A Records, Springfield State Hospital
1	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardie-vascular Disease UE TD Conditions If any which is
	gave rise to immediate cause (a), stating the underlying cause last.
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDUITION GIVEN IN PART 1(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDUITION GIVEN IN PART 1(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTIONS CONTRIBUTION GIVEN IN PART 1(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTIONS CONTRIBUTION GIVEN IN PART 1(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTIONS CONTRIBUTION GIVEN IN PART 1(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTIONS CONTRIBUTION GIVEN IN PART 1(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTIONS CONTRIBUTION GIVEN IN PART 1(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTIONS CONTRIBUTION GIVEN IN PART 1(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTIONS CONTRIBUTION GIVEN IN PART 1(a) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTIONS CONTRIBUTION GIVEN IN PART 1(a) PART II. OTHER SIGNIFICANT CONTRIBUTIONS
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	21. I certify that (I) (this hospital) attended the deceased from 9-27-63, 19 to 4-20-66, 19 that (I) (we) last saw the deceased alive on 4-20-66 19 and that death occurred at 3:3M, from the causes and on the date stated above 22a. SIGNATURE
	22c. PHYSICIAN'S NAME (Type) Octavio A, Ruiz, M.D. 22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784
	23a. BURIAL, CREMATION, 23b. DATE THEREDF 23c., NAME OF CEMETERY OR CREMATORY 23d., LOCATION (City, town or county) (State)
	24. FUNERAL DIRECTOR ADDRESS 250 REC'D BY REGISTRAR'S SIGNATURE LANGE LA

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ires that the death certificate be executed within 24 hours after death. physician. n signed by the attending physician and completely filled in by the funeral burial-transit permit. Then please remover carbon papers. Pages 1 and 2 burial, cremation, or removal, and in after death.		3.	DECEASED (Type or print) John — Sonn DEATH 4	Day Year
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D HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Page 4 may be retained by the hospital or attending physician. Trunsral DIRECTOR: After this certificate has been signed by director, page 3 should be detached for use as the burial-transhould be filed with the State Dept. of Health prior to burial, cred.		MEDICAL	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20d. (City or town) (Coursel of the plant work at work 20d. INJURY (Home, farm, factory, street, office bldg., etc.) 20d. (City or town) 20d. (Cit	unty) (State)
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TTEN Stain TOR Shou			saw the deceased alive on 4 - 6 1966, and that death occurred at 9.34M, from the causes and on the	
IREC 3			22b. Dignature	ATE SIGNED
AL CAL DILL DILL DIRECTOR	-		M.D. PHYS. DIRECTOR PHYS.	-8.66
TO HOSPITAL OR ATTENDING P Page 4 may be retained by t TO FUNERAL DIRECTOR: After director, page 3 should be should be filed with the State			NAME (Type) M. C. Porterfield/ Hampstead, Md.	
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND 0.5 12.8 CERTIFICATE OF DEATH 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY ource "a RROI MARYLAND by the CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENCTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) hours mak ucal = yon papers. filled d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital/glye street address d. STREET APORESS e. IS RESIDENCE ON A FARM? kovazu YES NO X executed within letely NAME OF First DATE Middle Last 4. Month Day DECEASED (Type or print) 66 DEATH Car 19 5. SEX 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In years [IF UNDER 1 YEAR] IF UNDER 24 HR\$ 7. MARRIED NEVER MARRIED last birthday) Months I Days Hours emo WIDOWED [DIVORCED [yrs. attending physician a ermit. Then please re on, or removal, and in a = 10a. USUAL OCCUPATION (Cive kind of work done) 12. CITIZEN OF WHAT COUNTRY? 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) death certificate be INDUSTRY during most of working life, even if retired) arro FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INEORMANT Address 17. been signed by the atten the burial-transit permit. In to burial, cremation, or (Yes, no, or unkown) (If yes give war or dates of service) 18. CAUSE OF DEATH [Enter only one cause per line for (a), NTERVAL BETWEEN (b), and (c), PHYSICIAN: The law requires that the the hospital or attending physician. ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which (b) gave rise to Immediate DUE TO cause (a), stating the prior underlying cause last. 98 (c) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART 1(a) 19. WAS AUTOPSY for use Health PERFORMED? certificate YES NO 17 20a. ACCIDENT WAS UNDERLYINC ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW IN DARY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) etached f Dept. of MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) det Hour a.m. factory, street, office bldg., etc.) Not While After 19 at work at work p.m. be retained DIRECTOR: A age 3 should iled with the 0 21. I certify that (I) (this hospital) attended the deceased from . 19 66 that MY (we) last and that death occurred at// M, from the causes and on the date stated above. saw the deceased alive on. 22a. SICNATURE DATE SICNED 22b. page filed MED. DIRECTOR ATTENDING PHYS. STAFF Page 4 may b FUNERAL ADDRESS 22c. PHYSICIAN'S director, p should be f NAME (Type) BURIAL, CREMATION, 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State) 23c. 23d. REMOVAL (Specify) 9 NION FUNERAL DIRECTOR REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE ADDRESS VR A15 (4) 20M 1/65



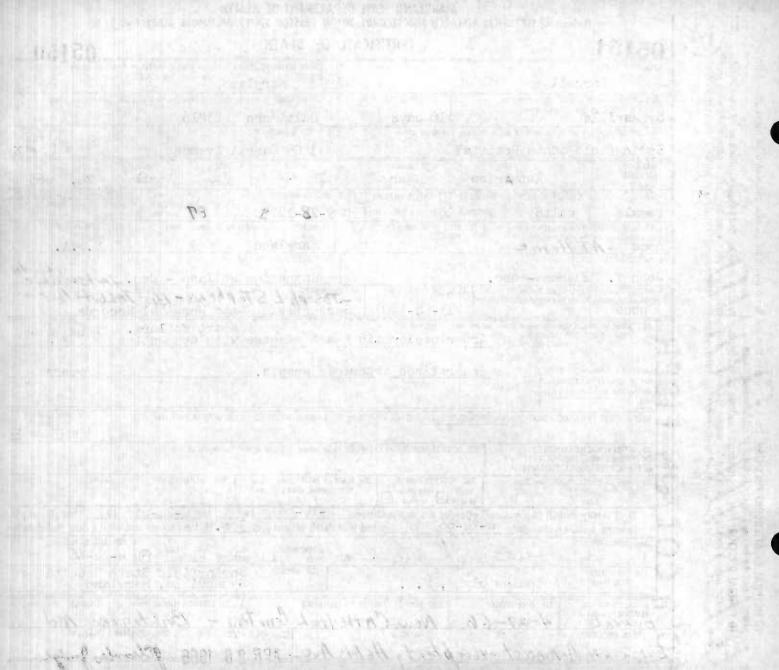
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ithin 24 hours are tely filled in by bon papers. Pag within 72 hours		d. NAME OF HOSPITAL OR-INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ON A FARM! VES D MODEL ON A FARM! VES D MODEL ON A FARM! ON
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OR ATTENDING be retained by JIRECTOR: After ge 3 should be ed with the Stat		saw the deceased alive on 1966, and that death occurred at 10 M, from the causes and on the date stated above
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TO HOSPITAL OR ATTENDI Page 4 may be retained TO FUNERAL DIRECTOR: A director, page 3 should should be filed with the		22c. PHYSICIAN'S NAME (Type) MMASTIM 22d. (ADDRESS MAME (Type) MMASTIM PER MAN.
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH within 24 haurs after death. death filled in by the funeral papers. Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) a. COUNTY Carroll o. STATE Maryland b. COUNTY Baltimore City MARYLAND and in any event, within 72 haurs after b. CITY OR TOWN (If outside carporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b write RURAL ond give neorest town)
Sykesville Baltimore 23vrs.2mos.6dvs. e. IS RESIDENCE ON A FARM? d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) Springfield State Hospital Exact address unknown YES NO K 3. NAME OF First Middle 4. DATE Month and campletely f remave carban Last Day Year DECEASED SIMES STEINER 25 19 66 ETHEL APRIL (Type ar print) DEATH be executed IF UNDER 1 YEAR IF UNDER 24 HRS. B. DATE OF BIRTH AGE (In years S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED birthdoy) Months Doys Hours Female White h-2h-1883 Sep . DIVORCED WIDOWED 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, ar foreign cauntry) 12. CITIZEN OF WHAT COUNTRY? INDUSTRY New York requires that the death certificate 14 MOTHER'S MAIDEN NAME 13 FATHER'S NAME crematian, or remaval, attending phy permit. Then John Mulligan Isabel Simes 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, no, orunknown) (If yes give wor or dotes af service) permit. 16-46-3747 Records, Springfield State Hospital INTERVAL BETWEEN CAUSE OF DEATH (Enter anly one cause per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: signed by the burial-transit p DAVS Severe bronchopneumonia IMMEDIATE CAUSE (o) **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the hospital ar attending physician. DUE TO burial Arteriosclerotic heart disease Years Conditions, if ony, which gove rise to immediate couse (a). DUE TO as the priar to b stating the underlying couse FUNERAL DIRECTOR: After this certificate has been Generalized arteriosclerosis Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) Schizophrenic reaction, parahoid type WAS AUTOPSY af far use a PERFORMED? CERTIFICATION NO X 205, DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City ar tawn) (County) (State) Hour a.m. While Nat While factory, street, affice bldg., etc.) at work ot work 21. I certify that (1) (this haspital) attended the deceased fram 2-19-43 __, 19____, that (I) (we) last M, from causes and on the date stoted above. and that death occurred at 0:05 4-25-66 19_ sow the deceased alive an 22b. DATE SIGNED 22a. SIGNATURE MED. DIRECTOR **ATTENDING** 4-25-66 M.D. PHYS directar, page 3 shauld be filed v 22d. ADDRESS Springfield State Hospital Agustin del Campo, M NAME (Type) Sykesville, Maryland 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 230. BURIAL CREMATION. (County) (State) Burial (Specify) /1966 Greenmount 0 Bal timore Md 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR **ADDRESS** York Road Sons .W.Jenkins Co Charles

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 24 hours after death. death sly filled in by the funeral son popers. Pages 1 and within 72 hours after deatl 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH o. COUNTY a. STATE b. COUNTY Carroll Maryland MARYLAND b. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) Sykesville Baltimore 27276 10 davs 0 d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 3405 Duvall Avenue Springfield State Hospital YES NO DC within 3. NAME OF 4. DATE pou First Middle Lost Month Doy Year DECEASED Katherine STEPHENS April 1966 24. Marv DEATH (Type or print) be executed IF UNDER 24 HRS. IF UNDER 1 YEAR S SEX B. DATE OF BIRTH AGE (In years 6. COLOR OR RACE 7 MARRIED NEVER MARRIED birthday) Manths Hours Days 9-28-1878 white WIDOWED TO DIVORCED crematian, or removol, and in any female 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even, if retired) INDUSTRY COUNTRY? requires that the deoth certificate Maryland none -AT Home 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John T. McMahon - dec. Katherine Wallace - dec. Tackcanvi IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address permit. (Yes, no, or unknown) (If yes give wor or dates of service) 213-54-1807 Springfield State Hospital Records none INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) heart failure. signed by the buriol-tronsit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE (AUSE (a) Arteriosclerotic heart disease with congestive buriol (b) Generalized arteriosclerosis. Conditions, if ony, which gove vears rise ta immediate cause (o) **DUF TO** stoting the underlying couse Page 4 may be retained by the hospital or ottending O FUNERAL DIRECTOR: After this certificate has been for use as the The low last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? CERTIFICATION NO Ex 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I ar Port II af item 1B.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH State Dept. of detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year Not While factory, street, office bldg., etc.) at wark at wark 21. I certify that (1) (this hospital) attended the deceased fram_ 4-14-55 to 4-24-66, 19, that (1) (we) lost . 19 3 should 4-24-66 and that death accurred at 3 p.M. from causes and an the date stated abave. saw the deceased alive an 22b. DATE SIGNED 22a. SIGNATURE 4-24-66 DIRECTOR PHYS. director, page 3 should be filed v 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S Antonius Glahr NAME (Type) M.D. ykesville. Maryland 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) BURIAL LTIMORE 2So. REC'D BY/REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66



O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and trady event, within 72 hours after death.

	WARTLAND STATE DEPARTMENT OF REALTH	
DIVISION OF STA	ATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MA	RYLANI
5152	CERTIFICATE OF DEATH	051
2 6 70 7		1

/1. PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. CDUNTY Carroll	a. STATE b. CDUNTY
b. CITY DR TDWN (if outside corporate limits. C. LENGTH DF STAY IN 1b	c. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town)
write RURAL and give nearest town)	
Rural, Westminster 6 Years	Rural, Westminster
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress)	d. STREET ADDRESS e. IS RESIDENCE DN A FARM?
Westminster, Md. R. D. 4	Westminster, Md. R. D. 4
3. NAME DF First Middle	Last 4. DATE Month Day Year
(Type or print) UERTIF A. STON	18.5/68 DEATH ADRIL 12 1966
5. SEX 6. CDLDR DR RACE 7. MARRIED NEVER MARRIED	8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.
Wente WIDDWED DIVDRCED	10/7/1896 last birthday Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of working life, even if retired) INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT
Housewife-Housework The Family Home	Carroll County, Md. CDUNTRY?
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Stonesifer	Ellen Stonesifer
(Yes, no, or unkown) ((f yes give war or dates of service)	INFORMANT Address
No 218-52-3477 Mr	s. Mazie Zepp Westminster, Md. R.D.1
18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).]	Core Luca A LINTERVAL BETWEEN DNSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	For TO A GUERN OCCAPATION OF
1/1/2	The state of the s
Conditions, If any, which	CANNI DIE 1000 Pen / tus
gave rise to immediate	1500 B
cause (a), stating the DUE TD	ousease pyrit
underlying cause last.) (c)	
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2Da. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCC	URRED. (Enter nature of injury in Part I or Part II of Item 18.)
PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT REL 20a. ACCIDENT WAS UNDERLYING 1 20b. DESCRIBE HOW INJURY OCC DR CONTRIBUTING 1 CAUSE OF DEATH (IF EITHER, NOT IFY MEDICAL EXAMINER)	
20c. TIME DF INJURY Month, Day, Year 20d. INJURY DCCURRED 20e. PL	ACE DF INJURY (Home, farm, 20f. (City or town) (County) (State)
While - Not while	ory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from	
	it death occurred at 100M, from the causes and on the date stated above.
22a. SIGNATURE	22b. DATE SIGNED
1 40000 MAN WOULD M.	D. ATTENDING MED. STAFF DIRECTOR PHYS. D 4-12-66
22c. PHYSICIAN'S	22d. ADDRESS
NAME (Type) ELEGGE WILKENS	5 15 remeron bestington
23a. BURIAL, CREMATION, 23b. DATE THEREDF 23c. NAME DF CEMETER	Y DR CREMATDRY 23d. LDCATIDN (City, town or county) (State)
REMDVAL (Specify)	
Burial 4/14/66 Bachmans Vall	
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH after death. and 1. PLACE DF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY b. COUNTY and completely filled in by the remove carbon papers. Pages 1 and event, within 72 hours after Carroll Maryland MARYLAND Maryland Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b hours Sykesville mos. 2 dys Hagerstown d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital 33 West Wilson Boulevard NO T YES executed within 3. NAME DE First Middle 4. DATE Month Day Year Last DECEASED TICE SUSAN STOUFFER (Type or print) DEATH April 19 66 5. SEX 6. COLOR OR RACE | 7. MARRIED DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. last birthday) | Months | Days | Hours | Min. NEVER MARRIED White Female WIDOWED T DIVORCED 10-23-1886 79 attending physician a ermit. Then please re 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

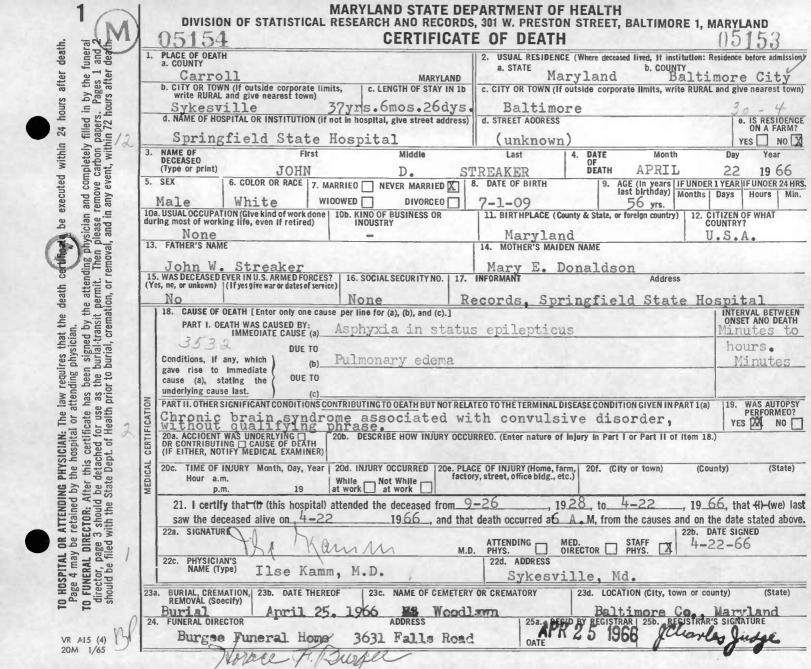
10b. KIND DF BUSINESS OR UNDUSTRY 12. CITIZEN OF WHAT = 11. BIRTHPLACE (County & State, or foreign country) pe COUNTRY? U.S.A. Maryland Seamstress that the death certificate 13. FATHER'S NAME 14. MDTHER'S MAIDEN NAME George Sterling Anna Newcomer 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) in signed by the attend burial-transit permit. burial, cremation, or re 16. SOCIAL SECURITY ND. 17. INFORMANT Address 220-05-6176A Records, Springfield State Hospital CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: physician. IMMEDIATE CAUSE (a) ARTERIOS CLEROTIC HEART DISEASE AN CEREBRAL ARTERIOS CLER OSIS YEAKS 4200 DUE TO requires Conditions, If any, which (b) GENERALIZED ARTERIOSCLEROSIS LEARS peen gave rise to immediate the hospital or attending r the DUE TO cause (a), stating the as the underlying cause last. certificate has (c) CERTIFICATION PARTII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Chronic brain syndrome associated with senile brain disease, with WAS AUTOPSY for use PERFORMED? psychotic reaction. YES NO X 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) ot o detached te Dept. of MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d, INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20f. (City or town) (County) (State) Hour a.m. While Not While FUNERAL DIRECTOR: After irector, page 3 should be chould be filed with the State be retained by at work at work 4-5-66 21. I certify that (I) (this hospital) attended the deceased from . 19 and that death occurred 3:15 R. Mom the causes and on the date stated above. saw the deceased alive on 22b. DATE SIGNED 22a. SIGNATURE STAFF PHYS. ATTENDING Page 4 may PHYS. M.D. DIRECTOR pringfield State Hospital PHYSICIAN'S NAME (Type) 22c. 22d. ADDRESS director, p Springfield State Maryland 21 Sykesville, Maryland 21 Campo, Agustin del LOCATION (City, town or county) 23a. BURIAL, CREMATION, 23b. DATE THEREOI 23c. NAME OF CEMETERY OR CREMATORY (State) REMOVAL (Specify) 9 FUNERAL DIRECTOR REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE **ADDRESS** Charley 1966 VR A15 (4) 15M 4-64

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after depth.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND OF DEATH OF DEATH

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	a. COUNTY Carrol		SEADY AND	a. STATE		b. COUNTY	more C		1
			MARYLAND c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (town)
	Write RURAL	VN (if outside corporate limits, and give nearest town)					-	11	
	Sykesv	1116	in hospital, give street address	dys. Balt	imore		30	IS RESI	DENCE
				d. STREET ADDRESS	5		0	ON A FA	ARM?
	Spring	field State Hos	pital	1733	Terrell	Place	Y	ES N	NO
	3. NAME OF OECEASEO	First	Middle	Last	4. OATE	Month	Oay	Year	
	(Type or print)	WILLI	AM (NMN)	SYKES	ÖEATH	Apri]	. 6	19	66
	5. SEX	6. COLOR OR RACE 7. MARE	RIEO NEVER MARRIEO	8. DATE OF BIRTH	9. /	AGE (In years IFU ast birthday) Mo	NDER 1 YEAR	IF UNDER	
	Male	White WICO	WEO DIVORCED	8-21-02		63 yrs.	nths Days	Hours	Min.
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	No			ecords, Spr.	ingfield	State Ho			
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	1120	DUE TO							
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	cause (a), s underlying cau	se last. (c) Fa:	r advanced pulmo	nary tuberc	ulosis.	active	y	ears	
	S PART II. OTHER	SIGNIFICANT CONDITIONS CONT	RIBUTING TO DEATH BUTNOT REI	LATEO TO THE TERMINAL	OISEASE CONOT	TION GIVEN IN PAR	T1(a) 19.	WAS AUT	
	Echronic	brain syndrome	associated with	brain traw	ma, gros	s force,	with YES	PERFORM	NO DE
2	20a. ACCIDENT	ic reaction.	b. DESCRIBE HOW INJURY OCC	CURREO, (Enter nature	of Inlury in Part	1 or Part II of It			
	PART II. OTHER Chronic psychot: 20a. Accioent or contribut (IF EITHER, NO	ING CAUSE OF CEATH OTIFY MEDICAL EXAMINER)							
			Od. INJURY OCCURRED 20e. Pt	ACE OF INJURY (Home,	farm 20f (C)	(ty or town)	(County)	(S)	tate)
	20c. TIME OF Hour a. p.		/hile - Not While -	tory, street, office bldg.,		ity or towny	(oount))	(0	
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		fy that (I) (this hospital) at	tended the deceased from_	12-1-59	18:15 12.	11-6-66	19, th	at (I) (w	e) last
		eceased alive on 4-6-4	56, and th	at death occurred at	M, fron	the causes and			above.
	22a./ SIGNATU	RE A) DA	n 1	ATTENDING	MEO.		b. DATE SIG		
	Kuli	der / adey	RENUMB M	.O. PHYS.	OIRECTOR	STAFF PHYS.	4-6-66		
1	22c. PHYSICI NAME (T	(una)				eld State			
	THAT (Julian Radzyke	ewycz, M.D.		Sykesvil	le, Maryl	and 217	784	
	23a. BURIAL, CREI		23c. NAME OF CEMETE	RY OR CREMATORY	23d. LOC/	ATION (City, town	or county)	(Sta	ite)
	REMOVAL (SP	1 4/9/66	Baltimore	e Cemetery	Bal	timore	Maryla	and	
	24. FUNERAL DIR	ECTOR	ADDRESS	25a. R		timore RAR 25b. REGIS	TRAR'S SIGN	ATURE	
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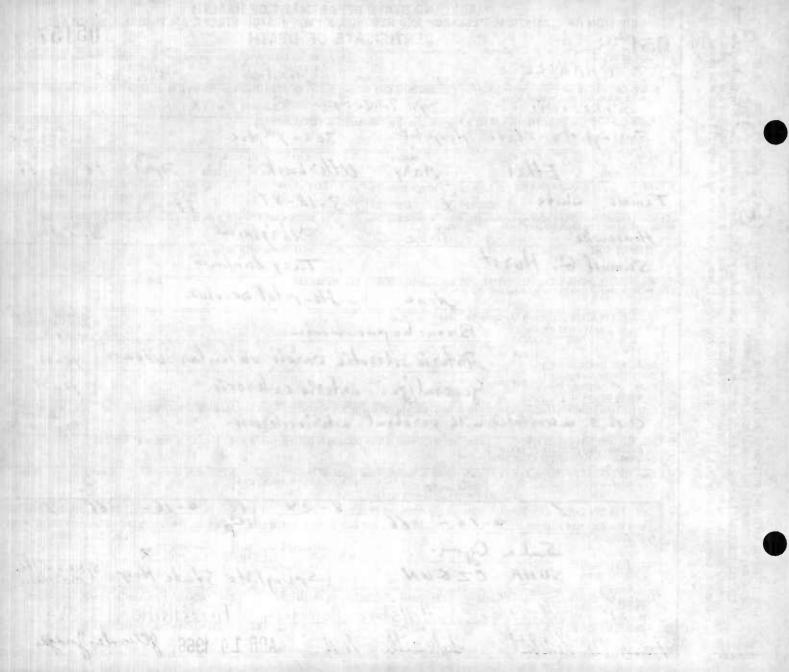
PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH should funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If institution, Residence before admission e. COUNTY hours b. COUNTY the strain arr MARYLAND and b. CITY OR TOWN (if outside corporeta limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 write RURAL and give neerest town) filled in Pages 1 after anchester within NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress) d. STREET ADDRESS . IS RESIDENCE ON A FARM? 8N mans YES NO papers. n 72 hou completely NAME OF Middle Lest 4. DATE Month Day Yeer DECEASED OF (Type or print) carbon pa DEATH 1966 ER 5. SEX 6. COLOR OR 9. AGE (In Yeers HE UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED pue ast birthdey) Months any event, WIDOWED DIVORCED attending physician please remove 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY & State, or foreign country) CITIZEN OF WHAT COUNTRY done during most of working life, even if retired usewi 13. FATHER'S NAME .5 and Then 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT requires that the removal, (Yes, no, or unknown) | (If yes give war or detes of service) certificate has been signed by the r use as the burial-transit permit. PHYSICIAN: The law requires the hospital or attending physician. 18. CAUSE OF DEATH [Enter only one cause per line for INTERVAL BETWEEN ONSET AND DEATH ö PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e cremation, DUE TO Conditions, if any, which gave rise to immediate cause DUE TO burial (a), steting the underlying cause fast. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | 19. WAS AUTOPSY CERTIFICATION as o PERFORMED? NO prior 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Pert I or Pert II of item 18.) for (IF EITHER, NOTIFY MEDICAL EXAMINER may be retained by the DIRECTOR: After this 3 should be detached f MEDICAL 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, ferm, ! 20f. (City or town) (County) (Stete) fectory, street, office bldg., etc.) Hour a.m. While Not While ŏ et work at work p.m. 1966, that 21. I certify that (I) (this hospital) attended the deceased from... (we) last1966..., and that death occurred at 9 .M.M. from the causes and on the date stated above saw the deceased alive on. 22a. SIGNATURE 22b. DATE ATTENDING SIGNED MED STAFF TO HOSPITAL death. Page 4 PHYS. DIRECTOR PHYS. M.D page with # 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) filed \ 23e. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (Stete) REMOVAL (Specify) Dig & 1966 Manchchester Cemetery Manchester Md. REGISTRAR 256. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE REC'D BY Tipton- Eline Funeral Home Hampstead, Md. 1966 VR A1S (4) 20M S-63

Michael Manner II. The Commissions Commission II Manner of the Commission of the Com

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		15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Yes, no, or unknown) [(If yes give war or dates of service)] Address	
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2	5 p &	urial April 28, 1966 Hampstead Cemetery Hampstead, Md.	tate
	B	4. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
VR	A15 (4)	ipton - Eline Funeral Home Hampstead, Md. DAMAY 2 1968 golden Judge	4

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1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND	
- 40M)	CERTIFICATE OF DEATH U5157	
hours after death. d in by the funeral rs. Pages 1 and 2. thours after death.	PLACE OF DEATH a. CDUNTY CARROLL MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before ad b. CDUNTY is the country of the co	mission
urs afte n by tho Pages ours aft	b. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville 3 yrs. 7m. 22 orys. Syunswick	t town
fille appear	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital 302-9th Ave. e. Is RESIDN A F	DENCE ARM? ND
executed within and completely remove carbon prompletely nany event, within	NAME DF DECEASED (Type or print) Ether Mary Utterboock DEATH Port 16 194	66
and con	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE DF BIRTH 9. AGE (In years list birthday) Hours Hou	24 HRS Min.
physician and in year, and in	USUAL DCCUPATION (Give kind of work done in most of working life, even if retired) 10b. KIND DF BUSINESS DR INDUSTRY 11 BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT CDUNTRY? COUNTRY? COUNTRY?	
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t the dun. In. In. In. In. In. In. In. In. In. I	18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia Cay S	WEEN
CIAN: The law requires that the ospital or attending physician. Certificate has been signed by the hed for use as the burial-transit t. of Health prior to burial, cremains	conditions, If any, which Due TD Anterio scherotic cardio vascular disease years	
aw requir ttending r has been as the b prior to b	gave rise to immediate cause (a), stating the DUE TD generalized anteriosclerosis. years underlying cause last. (c)	
The law or atte tate has use astath pr	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AU PERFORI	TOPSY MED? ND
CLAN: ospital certific hed for t. of Hi	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
PHY the the deta deta		tate)
D A D a	21. I certify that 40 (this hospital) attended the deceased from $8-24$, 1962 , to $4-16-$, 1966 , that 40 (we saw the deceased alive on $4-16 1966$, and that death occurred at 1250 M, from the causes and on the date stated	
OR ATTENDIOR ATTENDIOR SE retained SIRECTOR: A Se 3 should be with the State of with the State of Stat	22a. SIGNATURE Suha Ozem. ATTENDING MED. STAFF PHYS. M.D. PHYS. DIRECTOR PHYS.	abov.
TO HOSPITAL OR ATTEN Page 4 may be retaine TO FUNERAL DIRECTOR: director, page 3 should be filed with th	22c. PHYSICIAN'S NAME (Type) SUHA OZGUN 22d. ADDRESS Springfield State Hosp, Sikes vit Springfield State Hosp, Maryla	te
TO HOSPIT Page 4 m TO FUNERA director, should be	BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (St REMOVAL (Specify) 4-19-66 Hills Daro Cemetery Procedure, VA.	ate)
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15M 4-64		



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT. 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) 1. PLACE OF DEATH a. COUNTY b. COUNTY Carroll Carroll Maryland MARYLAND Department after death. cessary, funeral CITY DR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY DR TOWN (If outside corporete limits, write RURAL end give neerest town) c. LENGTH OF STAY IN 1b тау Rural, Westminster Rural. Westminster years the d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADORESS e. IS RESIDENCE DN A FARM? to ag State 82 E. Baltimore Road 82 E. Baltimore Road YES NO S 3. NAME OF Middle DATE Month Day Year the 72 DECEASED PAUL VARNELL April 1966 DEATH (Type or print) with 5. SEX 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. muo 2 wit last birthday) | Months | Deys Hours | Min. male white Nov. 21, 1925 WIDOWED [DIVORCED | event 1De. USUAL OCCUPATION (Give kind of work done | 10b. KIND DF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Merchant Seaman Kansas City, Missouri U.S.A. any pages in any 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Harvey Varnell Bess Carroll File 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes. no, or unkown) | (If yes give war or dates of service) permit. I Helen Mayerc Varnell same 18. CAUSE OF DEATH [Enter only one ceuse par line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: burial-transit cremation, or IMMEDIATE CAUSE (e) cremation, **OUE TO** Conditions, if any, which (b) gave rise to immediate DUE TO cause (a), stating the 40 used as a to burial, underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) WAS AUTOPSY CERTIFICATION PERFORMED? NO X YES 20a. EXTERNAL CAUSE WAS DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) PRIMARY OF CONTRIBUTING CAUSE OF DEATH. forwarded 3 should agent, pri he certificate, wri MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE DF INJURY (Home, farm, 20f. (City or hown) (County) (State factory, street, office bldg., etc.) While Not While CTOR: Page designated hould be 19 at work at work and in my opinion 21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry Files. Suicide > Undetermined manner death resulted from: Natural causes Accident Homicide DIRECTO CHIEF MEDICAL EXAMINER 4 for your Page DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE 0 DEPUTY MEDICAL EXAMINER FUNERAL Health **EXAMINER'S** retained Speicher director. NAME (Type) (City, town or county) NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION. DATE THEREOF 23c. 23b. REMOVAL (Specify) Brier Lafayette Hill, Penna. Cemetery 0 removal Apri 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR **ADDRESS** VR ALSME (5) 1/65

And military . County . Crear C. MARKET ILE CV Sign is work J. P. Primary, Aleby Maries nelen lavere Varieta le len N. Clenn Spileton 3. 5. Annal Trace of the second second party of the law ores

退	1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
141		05160 CERTIFICATE OF DEATH 05159
	hours after death. d in by the funeral rs. Pages 1 and 2 2 hours after death.	1. PLACE DF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission, a. STATE b. COUNTY
	after the f	CARROLL MARYLAND CARROLL
	by the Pages urs after	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
	in S. Found	HAMPSTEAD d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE
	24 fille pape in 7	ON A FARM? YES NO DE
	executed within and completely remove carbon rank event, with	3. NAME DF First Middle Last 4. DATE Month Oay Year DECEASED OF
	d w car car	(Type or print) GEORGE 7. WHEAT DEATH), 11 1966
	d co	last birthday) Months Days Hours Min.
		Male White WIDOWED DIVORCED October 12,1900 65 yrs. 10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT
		during most of working life, even if retired) INDUSTRY COUNTRY?
	+ > C ·	Carpenter Maryland USA 13. FATHER'S NAME 14. MOTHER'S MAIOEN NAME
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	certificate be inding physicial please in them please in removal, and it is the inding t	15. WAS DECEASED EVER IN ILS. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
	ING PHYSICIAN: The law requires that the death certifical by the hospital or attending physician. After this certificate has been signed by the attending ph be detached for use as the burial-transit permit. Then State Dept. of Health prior to burial, cremation, or removal	(Yes, no, or unkown) (If yes give war or dates of service) 214-03-7099 Mrs. Robert Utz, Hampstead, Md.
	the the ation	I 18. CAUSE DF DEATH Enter only one cause per line for (a), (b), and (c), 1
	h. hy ansi	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ONSET AND DEATH ONSET AND DEATH
	that icia ned ned al-tra al, c	4201 DUE TO
	phys sig surris	Conditions, If any, which \ (h)
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	endi endi is b is th rior	underlying cause last. (c)
	atte atte e he se a th p	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
	The lor under the leaf	YES NO D
	pita pita d fo of F	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
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	retaine retaine rector: 3 shoul with the	saw the deceased alive on 1905, and that death occurred at M, from the causes and on the date stated above
	de Re	ATTENOING WED. STAFF
	NL D	22c. PHYSICIAN'S 22d. ADDRESS
	SPIT 4 n VER tor, d b	NAME (Type)
	TO HOSPITAL OR Page 4 may be TO FUNERAL DIRI director, page should be filed	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
	5 5 5 2	Burial 4/14/66 Evergreen Mem. Gardens Finksburg Md.
	0.0	24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR' 25b. REC'STRAR'S SIGNATURE
	VR A15 (4) 15M 4-64	Tipton-Eline Hampstead, Md. DATAPR 18 1966 Icharles Judge

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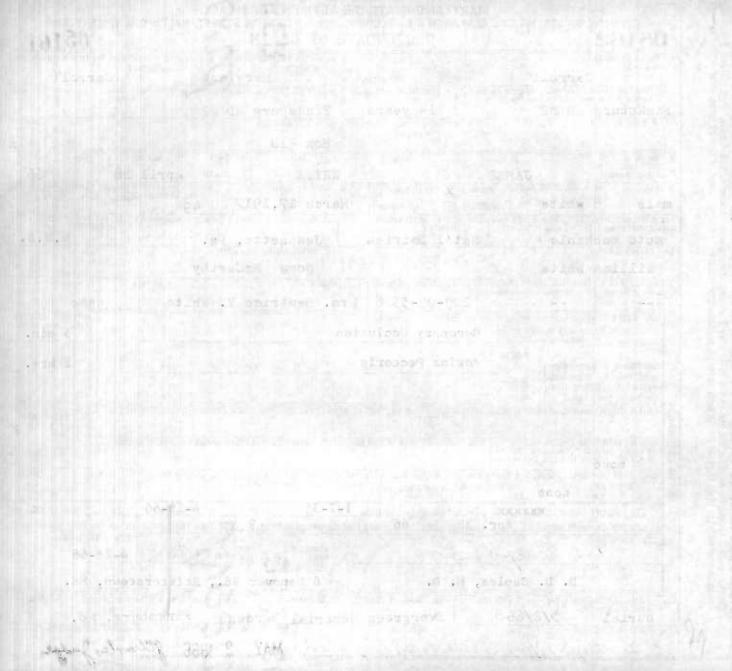
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 05161CERTIFICATE OF DEATH funera and death PLACE DF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY Carrell Marvland Carrel1 MARYLAND b. CITY OR TDWN (if outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b filled in by t papers. Page in 72 hours a write RURAL and give nearest town) hours Sykesville RD#4 Sykesville RD#4 8 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Near Sykesville Near Sykesville pag ND X YES within completely 3. NAME DE First Middle DATE Last Month Year 3 DECEASED WHIPP (Type or print) DANIEL Cal DEATH April 20. 19 66 executed 6. COLDR OR RACE | 7. MARRIED SEX DATE OF BIRTH e e 8. 9. last birthday) Months | AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. NEVER MARRIED and rem Male White Hours 1 March 1884 WIDOWED DIVORCED attending physician a ermit. Then please re = 1Da. USUAL DCCUPATION (Give kind of work done) 10b. KIND DF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT be during most of working life, even if retired) INDUSTRY COUNTRY? Retired-Farmer Farm Owner Adamstown. Md. U. S. death certificate 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Maria Shellman John N. Whipp 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY ND. | 17. INFORMANT Address been signed by the atten the burial-transit permit. or to burial, cremation, or (Yes, no, or unkown) (If yes give war or dates of service) No Mrs. Dora S. Whipp (Same as item #1) 219-36-2620 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: PHYSICIAN: The law requires that ti the hospital or attending physician. IMMEDIATE CAUSE (a) DUE TD Conditions, If any, which gave rise to immediate the lor to DUE TD 4-20-66 cause (a), stating the underlying cause last. as (c) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) certificate hither for use of Health p WAS AUTOPSY PERFORMED? ND X YES 2Da. ACCIDENT WAS UNDERLYING DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part 1 or Part II of Item 18.) is certi tached 1 bept. of OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 2Dc. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) der factory, street, office bidg., etc.) Hour a.m. After While Not While p.m. at work at work O HOSPITAL OR ATTENDII
Page 4 may be retained the FUNERAL DIRECTOR: A lirector, page 3 should hould be filed with the 21. I certify that (I) (this hospital) attended the deceased from that (I) (we) last shoul ith th and that death occurred a saw the deceased alive on _M. from the causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED ATTENDING STAFF 20 April 1966 M.D. DIRECTOR PHYS. PHYSICIAN'S TO FUNERAL director, p 22d. ADDRESS NAME (Type) BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) BUT121 (Specify) -23-66 Mount Olivet Cemetery Frederick, Md. 21701 24. FUNERAL DIRECTOR REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE M. R. Etchison &

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH death. funeral and and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY b. COUNTY filled in by the fundamental papers. Pages 1 in 72 hours after Carroll 24 hours after Maryland Carroll MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) bon papers. Page within 72 hours a 14 years Finksburg RD #2 Finksburg RD #2 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS Box 410 YES NO X uthin etely completely ove carbon NAME OF DECEASED 3. First Middle Last 4. DATE Month Day Year in any event, v 1966 WHITE April 28 (Type or print) JAMES DEATH executed 5. SEX 6. COLOR OR RACE 7. MARRIED X NEVER MARRIED DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months I Days Hours | Min. Months I Davs Hours and male white March 17,1917 WIDOWED DIVORCED [49 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) physician lease and ir certificate be COUNTRY? U.S.A. Nat'l Dairies auto mechanic Jeannette. Pa. removal, 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME r this certificate has been signed by the attending detached for use as the burial-transit permit. There bept. of Health prior to burial, cremation, or remov William White McCarthy Nora 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address (Yes, no, or unkown) (If yes give war or dates of service) PHYSICIAN: The law requires that the death the hospital or attending physician. 209-09-3388 Mrs. Beatrice V. White same INTERVAL BETWEEN ONSET AND DEATH 5 min. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Coronary Occlusion IMMEDIATE CAUSE (a) DUE TO Angina Pectoris 2 hrs. Conditions, If any, which (b) gave rise to immediate DUE TO cause (a), stating the underlying cause last. (c) CERTIFICATION WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? YES NO X 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (State) 20f. (City or town) (County) Hour a.m. TO FUNERAL DIRECTOR: After director, page 3 should be d should be filed with the State While Not While be retained by OR ATTENDING at work at work 21. I certify that (I) (t新述的数例数I) attended the deceased from 1-7-55 to 4-28-66 19 . 19. Apr. 28 19 66, and that death occurred at 9 A M, from the causes and on the date stated above. saw the deceased alive on_ 22b. DATE SIGNED 22a. SIGNATURE ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 4-28-66 Page 4 may b M.D. PHYSICIAN'S ADDRESS 22d. NAME (Type) D. D. Caples, M. D. Hanover Rd., Reisterstown, Md. 23b. DATE THEREOF 23d. LOCATION (City, town or county) 23a. BURIAL, CREMATION, 23c. NAME OF CEMETERY OR CREMATORY (State) REMOVAL (Specify) 5/2/66 Evergreen Memorial Finksburg, Md burial Gardens 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR ADDRESS VR A15 (4) 15M 4-64



1	41	MARYLAND STATE DEP DIVISION OF STATISTICAL RESEARCH AND RECORDS,	PARTMENT OF HEALTH , 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
÷	V	05163 CERTIFICATE	
funeral and 2	N	1. PLACE DF DEATH a. COUNTY	USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission a. STATE b. COUNTY
e e e	A	Carroll MARYLAND	Maryland Howard
S des	1	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town
9 E . 6	-	Sykesville 3 mos. 26 d	rs. Savage 13-2
24 hour filled in papers. P in 72 hou	, ,	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street eddress)	d. STREET ADDRESS e. IS RESIDENC ON A FARM?
	X	Springfield State Hospital	305 Commercial Street YES NO
ecuted within nd completely move carbon piny event, withi		3. NAME DF First Middle DECEASED	Last 4. DATE Month Day Yeer
ted wi	-	(Type or print) CHARLES WILLIAM 5. SEX 6. COLOR OR RACE 7. MADDIED NEVER MADDIED 1. NEVER MADDIED	WHITEHEAD DEATH April 20 19 66 B. DATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 HR
execute and co remove r any ev		/. MARKIED NEVER MARKIED	B. DATE OF BIRTH 9. AGE (In years FUNDER 1 YEAR FUNDER 24 HR last birthday) Months Days Hours Min
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ndin ren	-	Julius C. Whitehead 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17.	Clara M. Waskey INFORMANT Address
atter mit.		(Yes, no, or unkown) (If yes give war or dates of service)	
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requires that the death certific ding physician. been signed by the attending p the burial-transit permit. Then to burial, cremation, or remove		PART I DEATH WAS CAUSED BY.	ONSET AND DEATH
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NG P by th fter fter be d		Hour a.m. p.m. 19 While Not While ractor	J, street, onlooping, etc.)
= 0 4 7		21. I certify that (I) (this hospital) attended the deceased from	12-24-65, 19 to 4-20-66, 19 that (I) (we) la
L OK ATTENDI y be retained DIRECTOR: A age 3 should		saw the deceased alive on 4-20-66 19, and that	death occurred at
R A REC		22a. SIGNATURE	ATTENDING MED. STAFF 22b. DATE SIGNED
		M.D.	PHYS. DIRECTOR PHYS. X 4-20-06
TO HOSPITAL Page 4 may O FUNERAL D director, pag should be file	1	22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS Springfield State Hospital
Page / FUNI direct	-	Octavio A. Ruiz, M.D. 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY	OR CREMATORY 23d. LOCATION (City, town or county) (State)
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH 05163 05164 2 executed within 24 haurs after death completely filled in by the funeral nove carban papers. Pages 1 and y event, within 72 hours after degst PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY Carroll Maryland Allegany MARYLAND b. CITY OR TOWN (If outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b. write_RURAL and give neorest town) Riral--Sykesville 13 days Cresaptown d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital YES NO TO 3. NAME OF Middle 4. DATE emove carban Lost Month Doy Year DECEASED OF 19 66 Belle Zarger (Type or print) Marv DEATH S SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE B. DATE OF BIRTH AGE (In years 7. MARRIED NEVER MARRIED birthdoy) Months Hours Doys 6/10/86 white WIDOWED DIVORCED female 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT the death certificate be during most of working life even if retired) COUNTRY? Maryland - Artemas, Pa. USA 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME cremation, ar remaya Eliza Leasere Simon Clingerman 16. SOCIAL SECURITY NO. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) permit. Springfield Hospital records -- Sykesville unknown INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the burial-transit p Cardiac failure due to myocardial infarction oddy's DEATH PART I. DEATH WAS CAUSED BY: requires that IMMEDIATE CAUSE (o) DUF TO burial, Arteriosclerotic cardiovascular disease Conditions, if ony, which gove years rise to immediate couse (a). DUE TO been as the priar tak stoting the underlying couse Page 4 may be retained by the haspital or attending Chronic bronchitis years **TO FUNERAL DIRECTOR:** After this certificate has director, page 3 should be detached far use as shauld be filed with the State Dept. af Health pri PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? Chronic brain syndrome associated with senile brain disease with psychotic reaction.

200. ACCIDENT WAS UNDERLYING | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I of item IR) YES -NO OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, (City or town) (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED (County) Not While foctory, street, office bldg., etc.) 19 ot work , 1966_, ta_ 4/17/ ____, 19.66, that (\$\text{we}\$) last 21. I certify that the (this haspital) attended the deceased fram. 19 66, and that death accurred at 11,30 M, fram causes and an the date stated above. saw the deceased alive an 22b. DATE SIGNED 220. SIGNATURE MED. DIRECTOR 4/17/66 M.D. PHYS. PHYS. Springfield State Hospital 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) Maneeratana Fuangvudhiran, M.D. Sykesville. Maryland 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. DATE THEREOF (County) (Stote) REMOVAL (Specify) April 21,1966 Hillcrest Burial Park Cumberland, Ma. **ADDRESS** BI REGISTRAN 2Sb. REGISTRAR'S LIGHATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 James F. Scarpelli, Cumberland, Ma.

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13/	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
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iours afte in by the s. Pages hours aft	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RUFA Sykesville Month Sykesville
ithin 24 hour tely filled in oon papers. within 72 hou	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) Linger Nursing Home Springfield Ave. 6. IS RESIDE ON A FARM YES NO
ted within completely be carbon pevent, within	3. NAME-OF DECEASED (Type or print) Frederick W. Zimmerman 4. DATE Month Day Year OF DEATH April 25, 1966 5. SEX 6. COLOR OR RACE 7. MARRIED 7. NEVER MARRIED 8. DATE OF BIRTH 9. AGE ON YEAR IIF UNDER 14 PARIE 19. AGE
executed	Marke White WIDOWED DIVORCED 8-26-1886 The year Months Days Hours N
icate be physician n pleas val, and i	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11b. BIRTHPLACE (County & State, or foreign country) 12c. CITIZEN OF WHAT COUNTRY? COUNTRY? A 13. FATHER'S NAME
ath certifice attending pl rmit. Then n, or remova	ZACHARY ZIMMERMAN ANDIE C. BACK 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address
nt the death can. J by the atten ransit permit. cremation, or	(Yes, no, or unkown) (If yes give war or dates of service) 7 MRS. Nellie Zimmerman - Sykesville, 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEE
requires that the death certificate be executed within 24 hours after death ding physician. been signed by the attending physician and completely filled in by the funeral the burial-transit permit. Then pleas remove carbon papers. Pages 1 and 2 for to burial, cremation, or removal, and in any event, within 72 hours after death.	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO DUE TO ONSET AND DEATH ONSET AN
law requires that tattending physician, has been signed be as the burial-tranh prior to burial, cre	Conditions, If any, which gave rise to immediate cause (a), stating the DUE TO CAR DELLE COLUMN COLUMN COLUMN COLUMN COLUMN CARROLLE CAUSE (B) CARROLLE CAUSE (CARROLLE CAUSE
The law or attenuate has use as salth prio	underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) (1) PERFORMED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) (1) PERFORMED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) (1) PERFORMED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) (1) PERFORMED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) (1) PERFORMED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) (1) PERFORMED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) (1) PERFORMED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) (1) PERFORMED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) (1) PERFORMED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) (1) PERFORMED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) (1) PERFORMED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) (1) PERFORMED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) (1) PERFORMED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) (1) PERFORMED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) (1) PERFORMED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) (1) PERFORMED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) (1) PERFORMED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) (1) PERFORMED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) (1) PERFORMED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) (1) PERFORMED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) (1) PERFORMED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) (1) PERFORMED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) (1) PERFORMED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a)
PHYSICIAN: The law the hospital or atten this certificate has detached for use as e Dept. of Health price	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOF PERFORMENT OF JUNE 10. ACCIDENT WAS UNDERLYING 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Pert 1 or Pert II of Item 18.) 20 CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State factory, street, office bldg., etc.)
TO HOSPITAL OR ATTENDING I Page 4 may be retained by to O FUNERAL DIRECTOR: After director, page 3 should be of should be filed with the State	21. I certify that (I) (this hospital) attended the deceased from 1800 26 , 1965, to 1965, to 1966, that (I) (we) saw the deceased alive on 1960 25 1966, and that death occurred at 1960, from the causes and on the date stated ab
AL OR A lay be ru L DIREC page 3 filed wi	22a. SIGNATURE Same Claud man M.D. ATTENDING MED. STAFF 22b. DATE SIGNED PHYS. DIRECTOR PHYS. 1 22c. PHYSICIAN'S 1 22d. ADDRESS 1 22d. ADDRESS 1 22d. ADDRESS 1
0 HOSPITAL Page 4 may 0 FUNERAL I director, pag	NAME (Type) Sani Okutman Sykesville, Md.
Total de la	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) 4-28-66
VR AI5 (4) 20M 1/65	Harry W. Haight Sykopithe, Md. MAY 2 1966 Juliantes Judge

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